DEPARTMENT OF VETERANS AFFAIRS PHARMACY PROGRAM WITH EMPHASIS ON OTC DRUGS, MEDICAL SUPPLIES AND DIETARY SUPPLEMENTS

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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DEPARTMENT OF VETERANS AFFAIRS PHARMACY PROGRAM WITH EMPHASIS ON OTC DRUGS, MEDICAL SUPPLIES AND DIETARY SUPPLEMENTS

TUESDAY, JUNE 11, 1996

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 10 a.m., in room 334, Cannon House Office Building, Hon. Tim Hutchinson (chairman of the subcommittee) presiding.

Present: Representatives Hutchinson, Smith, Quinn, Edwards, Kennedy, Clement, Tejeda, Bishop and Doyle.

OPENING STATEMENT OF CHAIRMAN HUTCHINSON

Mr. HUTCHINSON. The subcommittee will now come to order.

The subcommittee meets today as part of its oversight responsibility to examine VA's policy of dispensing by prescription over-the-counter drugs or other medical products. Over-the-counter drugs and products are defined as commonly available, nonprescription medications, medical supplies and dietary supplements that are available to the general public through the private retail market, such as drugstores, groceries or any other store or outlet.

An illustration I have before us today, some of the nonprescription drugs which VA drugs doctors prescribe for their veteran patients. These include Tylenol, Bufferin, Bayer Aspirin and Ensure liquid supplement. These products highlight just a few of the 15 million over-the-counter products that were dispensed at VA medical centers last year at an estimated cost of $165 million.

The VA pharmacy system is a $1 billion a year program which operates a nationwide system of 165 pharmacies and last year filled over 65 million prescriptions. Of this total, GAO estimates that 25 percent were filled for over-the-counter drugs and products.

In addition to the standard pharmacy program of dispensing inpatient and outpatient drugs, the VA also operates an automated and consolidated mail-out prescription service or CMOPS program. The consolidated automated program which operates at four sites fills 33 percent of all VA mail-out prescriptions and has been estimated to have produced operational savings of $13 million a year while simultaneously improving customer service.

The VA pharmacy program is critical to the provision of quality patient care for our Nation's veterans. In today's budget climate, it is important that VA pharmacy expenditures are examined within the framework of what is the most prudent and economical use of taxpayer resources. It is for this reason that I asked GAO to examine the over-the-counter aspect of VA's pharmaceuticals.

Approximately 6 months ago, a career VA physician presented me with a large bag of over-the-counter medications and dietary supplements. His statement that eliminating these items from the hospital formulary would save hundreds of thousands of dollars from his medical center's budget that could then be channeled into other patient care needs was very intriguing to me and the catalyst for the GAO analysis.

It is important to recognize that some over-the-counter drugs such as insulin and possibly aspirin play an important role in maintaining effective management of chronic conditions, which, if left untreated, could become life-threatening and ultimately much more costly to treat. However, larger questions remain, such as which over-the-counter products are appropriately dispensed by the VA pharmacy system, which products should be the responsibility of the veteran patient, and what are the policies of other providers such as medicare, private insurers and other managed care entities with regards to such products? These are the types of questions and issues this hearing will examine this morning.

I thank our witnesses for joining us today and recognize my friend and colleague, the ranking member of the subcommittee, Chet Edwards, for his opening statement.

OPENING STATEMENT OF HON. CHET EDWARDS

Mr. EDWARDS. Thank you, Mr. Chairman. With your approval, I would like to submit an opening statement to the record, and I will save the committee time from reading that.

Mr. HUTCHINSON. Without objection.

Mr. EDWARDS. I want to thank you for holding this hearing, Mr. Chairman, and I openly welcome an effort to look at ways to make our VA more efficient and consistent in its policies, particularly with the pharmacy program. I know there have been real questions raised about consistency of service and also efficiency of service. I think those are very appropriate questions for us to address, and I hope we can find some solutions to solving those problems.

I think especially it is important now in light of what is happening today on the House Floor. We are going to vote on a budget resolution that freezes the VA medical program, and in light of inflation and increasing numbers of World War II and Korean veterans that need health care, in effect, I think we are going to see some real problems with VA health care budgets around the country if that budget becomes the law of the land and drives our budget decisions this year. And for that reason, every dollar we can save through this type of hearing is a dollar we can hopefully provide to minimize the potential reduction of VA health care services to our Nation's veterans.

I will keep an open mind, Mr. Chairman, but I also want us to be very careful before we decide that we are not going to offer cer-

tain medical services to our veterans, including nonprescription drugs.

I would remind all of us that there are only two types of veterans essentially getting care today through our VA health system, those, one, that are service-connected—and I think we need to question, you know, how much more out-of-pocket health care expenses do we want our service-connected veterans to pay, if we change our policies; and, two, the second kind of veteran that gets care in our VA system is essentially the impoverished veteran. And whether it is prescription or nonprescription, these drugs could be a very expensive item for them to start having to pick up as out-of-pocket health care expenses when you consider they wouldn't get VA health care in the first place if they made much of any money.

So I have some concerns and serious questions about the issue of how far we want to go in cutting out services to veterans, but I am certainly open-minded to hear all points of view considering that we have got a budget on the Floor that would freeze VA health care budgets and not allow for any additional expenses that are forced by inflation.

So I thank you for having the hearing, Mr. Chairman. I think this will be a productive meeting, and I think we will find some ways to save some money for the VA health care system as a result.

[The prepared statement of Congressman Edwards appears on p. 37.]

Mr. HUTCHINSON. Thank you, Chet.

Mr. Doyle, did you have an opening statement?

Mr. DOYLE. Not right now, Mr. Chairman. Thank you.

Mr. HUTCHINSON. The subcommittee will hear testimony this morning from two panels on the issue of over-the-counter drugs and products. I would like to welcome the first panel from the General Accounting Office, panelists composed of Mr. David Baine, Director of Health Care Delivery and Quality Issues, Health and Human Services Division. He is accompanied by Mr. Paul Reynolds, assistant director of the division; Mr. Walter Gembacz, senior evaluator in the division. Thank you for coming.

I would ask the witnesses to summarize your testimony. The full text will be entered into the record.

This morning, the subcommittee will operate under the 5-minute rule.

The chair recognizes Mr. Baine.

STATEMENT OF DAVID P. BAINE, DIRECTOR, HEALTH CARE DELIVERY AND QUALITY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION, U.S. GENERAL ACCOUNTING OFFICE, ACCOMPANIED BY: WALTER GEMBACZ, SENIOR EVALUATOR, HEALTH CARE DELIVERY AND QUALITY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION; AND PAUL REYNOLDS, ASSISTANT DIRECTOR, HEALTH CARE DELIVERY AND QUALITY ISSUES, HEALTH, EDUCATION, AND HUMAN SERVICES DIVISION

Mr. BAINE. Thank you, Mr. Chairman. Good morning.

Thank you for inviting us today to discuss VA's provision of over-the-counter medications and other products. In recent years, VA of-

ficials have testified that resources are not sufficient to serve all veterans seeking care and that they expect such shortages to worsen in the future years. Others have questioned whether VA pharmacies' provision of over-the-counter products represents the most prudent and economical use of VA's available resources.

You provided in your opening statement, Mr. Chairman, some background information which I won't repeat. In summary, Mr. Chairman, our work has shown that all VA pharmacies provide veterans with medications and medical supplies that are available over the counter. For example, VA pharmacies dispensed analgesics such as aspirin almost 3 million times last fiscal year. Each pharmacy, however, offers a unique package of products, and some restrict which veterans may receive over-the-counter products or in what quantities they may receive them.

VA recovered an estimated $7 million through veterans' copayments, or about 4 percent of its $165 million dispensing costs for these products. Individually, veterans' costs vary depending upon the types of products and the veteran's eligibility status. Although many veterans shared a modest portion of the costs, some paid more than full cost, most veterans paid nothing.

Most VA facilities offer an over-the-counter product benefits package that is more generous than other health plans. Other plans cover few, if any, OTC products for beneficiaries. As a result, VA facilities have devoted significant resources to the provision of such products which other plans have elected not to spend.

There are several ways, in our opinion, that VA's resources devoted to the dispensing of OTC products could be reduced or revenues from copayments could be enhanced. First, VA facilities could reduce their pharmacy costs if eligibility criteria are more strictly administered for over-the-counter products. Less than half of the veterans receiving outpatient care have service-connected conditions. Thus, most veterans must meet the pre-hospitalization, post-hospitalization or obviate the need criteria, which we talked about a couple of weeks ago.

In our view, many veterans may be receiving OTC products for nonservice-connected conditions unrelated to a VA hospital stay. Toward this end, VA may need to provide better guidance to facilities to achieve an effective and consistent use of OTC products within the statutory authority.

Second, VA facilities could reduce their costs if they restructured OTC product dispensing and copayment collection processes. In general, most facilities handle the products too often, mail the products too often, and allow veterans to delay copayments too frequently. Although some facilities have adopted measures to operate more efficiently, all facilities could benefit from doing so.

Third, VA facilities could further reduce the number of OTC products available to veterans on an outpatient basis. VA should be commended for instructing network directors to consolidate their formularies. This action, which is currently in progress, has not yet achieved an adequate level of consistency or cost containment systemwide, but it is fair to say that VA is working on this.

Because the network's current formularies approximate the more generous coverage of OTC products, some networks are allowing facilities to have less generous OTC benefit packages. This is likely

to result in a continuing uneven availability of these kind of products. Given the disagreement among networks and facilities regarding the provision of OTC products, additional guidance may be needed to ensure that veterans have a consistent level of access to such products nationwide. In light of concerns about potential resource shortages, tailoring the availability of OTC products to be more in line with those less generous facilities might be desirable. This would essentially limit OTC products to those most directly related to VA hospitalizations.

Fourth, expanding veterans' share of the costs would also help to reduce Federal resource needs. This could be achieved by expanding copayment requirements to include medical supplies, which are not now covered by copayments, reducing the income threshold for veterans with nonservice-connected conditions, or increasing the amount of copayments required.

Finally, VA facilities have developed ways to provide products to veterans outside their pharmacies at costs lower than they are available through other local outlets. Some facilities, for example, have had success using the Canteen Service stores at the medical centers to stock and sell over-the-counter products that the facilities had removed from their formularies. This also seems to be a reasonable alternative to providing OTC products to veterans through VA pharmacies.

That, basically, is a summary of a fairly long statement for the record, and we will be more than happy to take any questions from you or other subcommittee members.

[The prepared statement of Mr. Baine appears on p. 40.]

Mr. HUTCHINSON. Thank you, Mr. Baine.

Mr. Edwards raised the whole issue of eligibility and that we should just be having those who are impoverished and those who have service-connected disabilities. In your statement, you said less than half of those who are receiving the over-the-counter prescriptions are, in fact, suffering with service-connected disabilities.

Did you find that current eligibility rules are widely ignored in the practice of dispensing the over-the-counter prescription?

Mr. BAINE. We have talked about that some, I believe, a few weeks ago, at your eligibility reform hearing. And I think it is fair to say that physicians at VA facilities across the country tend to try to treat all medical needs of the patient. If it means winking at the eligibility rules, that is what happens in many cases; not in all cases, but in many cases. And as we had talked about also in the access point hearing that you had, that was the case.

Mr. HUTCHINSON. In your testimony, you stated that over-the-counter drugs account for 25 percent of all prescriptions filled nationwide, and that they represent as little as 7 percent in one facility and as much as 47 percent of another facility's workload. Could you describe what type of facility would be able to support an over-the-counter prescription level of 47 percent or would even want to have such a policy where you had that generous provision?

Mr. BAINE. I believe that facility is a nonaffiliated facility. It is not a teaching hospital. It provides essentially primary care services, and perhaps the director of the facility has decided that the use of over-the-counter medications for his or her patient population is the right thing to do.

It sounds high. It sounds high to me. But as you know, medical center directors have a fairly wide latitude in how they spend their money and the kinds of resources they put into these facilities.

Mr. HUTCHINSON. Well, it creates a—I mean, that would be a tremendous disparity, though, in the treatment that veterans are receiving across the country from various facilities, from 7 percent in one to 47 percent——

Mr. BAINE. Sure.

Mr. HUTCHINSON (continuing). In another. So if you want to talk about equity and fairness to veterans, it would seem that that would be hard to justify, at least in my mind.

Mr. BAINE. We took a look, sir, at the facility that reported to us that 47—the 47 percent number. And like I said, it was a nonaffiliated, nonteaching hospital, which might not have provided as many specialized services which would require legend drugs as some of the other facilities in the system.

Mr. HUTCHINSON. In your report, you mentioned that mailing and repackaging drive up the costs of over-the-counter drugs. What do personnel and mailing add to the cost of such frequently prescribed products as Tylenol or laxatives, and what does it cost to package and mail a case of, say, Ensure, which is liquid and very heavy? What kinds of costs do we incur on those kinds of things?

Mr. BAINE. The packaging and personnel costs, I believe, run around $2.50 or $3 per prescription filled. The mailing costs vary, of course, depending upon the type of product that is mailed. It costs a lot less money to mail aspirin, for example, than it does to mail a can of Ensure. We looked at what it would cost to mail a case of Ensure, and it's around, I believe, $8 to $10.

Mr. HUTCHINSON. Diapers would be another heavy product that——

Mr. BAINE. Right.

Mr. HUTCHINSON (continuing). I suppose, again, the cost would be something comparable.

Mr. BAINE. I think we had in the statement that the mailing cost of a case of Ensure was $17.50 or close to that.

Mr. HUTCHINSON. In your report, you mentioned some VAs now stock these over-the-counter drugs in their canteens. Could you estimate the price differences and savings for items such as aspirin, laxatives, liquid supplements as compared to their purchase at a commercial retail outlet? Are they comparable, or are there genuine savings there for veterans at the canteen? Is that a viable option for us to not have the over-the-counter prescriptions offered to the extent they are now, or to put a more restrictive policy in place and make the option that veterans could purchase those at a reduced price at the canteens?

Mr. BAINE. That is an option that has been exercised by some medical facilities across the country. If the canteens were to purchase generic products, such as generic aspirin you are probably looking at a cost savings of 30 to 40 percent from what it would cost the veteran at a retail outlet.

There is another option here. If the medical center's pharmacy service were to buy the product and then provide it to the canteen, the savings could be more than that, because VA gets such a good price on some of these products.

So it depends on which portion of the VA would actually buy the product, I think. But roughly it is 30 to 40 percent, I think, in terms of cost to the veteran.

Mr. HUTCHINSON. And the VAs that have tried that option, where they are using the canteen and limiting the amount of over-the-counter prescriptions offered, did you find that they were successful and what kind of reaction did veterans have? Were you able to determine any of that in your survey?

Mr. BAINE. Walter, Paul, do you want to respond?

Mr. REYNOLDS. Yes, I think that most of them were pretty positive about it and upbeat; however, some of them found that when they did move the products to the canteen, the canteen was willing to stock them as long as they would keep moving and the veterans would buy them. Some of the items didn't move, and so they stopped stocking them. But for the ones that did move, it was pretty successful, and they were positive about it.

Mr. HUTCHINSON. Mr. Edwards.

Mr. EDWARDS. Thank you, Mr. Chairman.

Mr. Baine, again, thank you for your comments. I especially think in today's real world of budget constraints we have got to find a way to do things more efficiently, and your suggestions to consolidate purchasing, and to purchase products on a more efficient basis, make sense.

Clearly, I think it is important that the chairman has allowed us to look at the issue. Apparently there is a different policy at every VA medical center in the country. That doesn't make sense. There ought to be some consistency.

One of your suggestions is that we ought to have stricter eligibility requirements. I just want to be clear, that is really a policy decision to be made by Congress rather than a process decision to be made by the GAO. Is that correct? Would you agree with that?

Mr. BAINE. That is absolutely correct, and I don't believe that we were saying that there ought to be stricter eligibility rules. I believe that what we are trying to point out is that the eligibility rules that are currently on the books are not being followed by the medical centers, and until such time as those are changed, it seems to us reasonable to expect that greater adherence to the eligibility requirements would make sense, Mr. Edwards.

Mr. EDWARDS. Right. But in terms of making a recommendation then, so that I am clear: you don't really see it as your place to make a recommendation that we increase out-of-pocket health care costs for service-connected veterans or that we increase out-of-pocket health care costs for low-income or impoverished veterans; is that correct?

Mr. BAINE. That is correct. We have done work in the last 2 years where we have tried to point out the implications of doing one thing or another from a policy standpoint.

Mr. EDWARDS. Right.

Mr. BAINE. But that is certainly not our call. That is certainly your call. And I think you will find in every case where we have tried to point this out, we put it under a heading of "Matters for Congressional Consideration."

Mr. EDWARDS. So when you in your proposal say VA could increase restrictions on OTC products, you say verbatim, VA facilities

could adopt less generous policies for OTC products which would be more consistent with other health plans.

Of course, other health plans don't take into account that people served their country, put their lives on the line for the country, may have become injured, nearly lost their lives because of their country.

I just want to make it clear that you say they could do this. You are basically saying, if our committee chooses as a policy decision to save money by increasing the expenses, health care expenses for veterans, then this is one way to do it; is that correct?

Mr. BAINE. Yes. In that particular case, I think what you have across the VA system, Mr. Edwards, are instances and examples where the facilities themselves have put a restriction on the amount of over-the-counter products that are available to the veterans in those areas. That is an administrative call.

Mr. EDWARDS. Right.

Mr. BAINE. And when we went down to talk to the people at VA about this job, we pointed out to them that almost all the answers in terms of increased efficiency as they relate to over-the-counter products lie somewhere in the VA system itself, because there are facilities that have done things to enhance efficiencies.

With regard to eligibility, with regard to the amount of copayments and those kinds of things, that is certainly a decision, though, for the Congress.

Mr. EDWARDS. Very good. I just want to be sure that we separate out the efficiency questions and the consistency questions from what I think is a clear congressional policy decision.

Mr. BAINE. Absolutely.

Mr. EDWARDS. And this Congress may decide on a policy basis that we do, because of limited budgets, have to ask veterans to spend more out of pocket for health care costs. I just want to be sure that we separate GAO's role from making recommendations on efficiencies versus getting in the field of suggesting policy, and so I understand you are not suggesting a policy change. You are saying that if we choose to make a policy change, these are some of the things we could do.

Let me ask you this: If we did make a policy change, and we said because of the budget limits on VA health care, we have to make some tough choices. Human nature being what it is, physicians in VA hospitals being there to a large degree because they care about veterans and they have personal relationships with many of their patients, do you see a possibility that if we were to strictly limit the number of OTC drugs that could be offered to veterans through our VA medical centers, that VA physicians might be encouraged or tempted to try to go to prescription so that these people could get? It would end up, frankly, getting a prescription drug to take care of the same problem when one of these less expensive drugs would do.

Mr. BAINE. I think it is entirely possible that you could see some of that. If my memory serves me right, I believe that the Defense Department, back in 1990 or something, decided to take over-the-counter products out of the military hospitals, pharmacies, or formularies. And they found that some substitution was taking place because of the prescribing habits of doctors and so forth.

Therefore they put back a few. But I think they put back perhaps less than a dozen products on the formularies.

So this is something that can be adjusted almost continuously as experience is gained with the use of the products. But I think you could expect some substitution.

Mr. EDWARDS. Okay. And by a general nature, prescription drugs are more expensive than over-the-counter drugs?

Mr. BAINE. Absolutely.

Mr. EDWARDS. So we might not save $165 million if we eliminated all over-the-counter drugs, but something less than that? We would just have to estimate how much that would be, I guess. Thank you.

Mr. BAINE. I believe that is correct, because I think you would have a substitution problem. I don't want anybody to get the wrong impression that over-the-counter products are not necessary. They are absolutely medically appropriate in many cases. For example, aspirin to be taken by a patient after a stroke or heart attack is absolutely appropriate. And so these would be, tough calls, as you try to draw down the number of products that are generally available on the VA formulary.

Mr. EDWARDS. Very good. Thank you, Mr. Chairman.

That you think, Mr. Baine.

Mr. HUTCHINSON. Thank you, Mr. Edwards.

In your report, and I can't recall—you gave some incidents of where facilities had actually—in their formulary were more restrictive and had not had the experience of seeing more expensive prescriptions substituted, that they had not had a big problem; is that correct?

Mr. BAINE. I believe that is correct, sir. Yes, sir.

Mr. HUTCHINSON. And while some over-the-counter drugs or over-the-counter products may be very well justifiable, as you pointed out, it could be argued certainly, I think, clearly that some, Ensure, dietary supplements, Tums, that there are a lot of products that currently are being dispensed or prescribed, that may not be necessary to preclude a more expensive treatment or hospitalization.

Mr. BAINE. Yes. And there are instances, Mr. Hutchinson, where a product like Ensure is an important product for a patient such as those patients who are tube-fed. And there are going to have to be decisions made about do you restrict Ensure, for example, to those patients who are being tube-fed?

So each one of these products has some utility for particular conditions and particular veterans. And those are the kinds of decisions that are going to have to be made.

Mr. HUTCHINSON. But it seemed to me, in response to what Mr. Edwards, the ranking member, said, that there is several issues here, and one is the wise allocation of very scarce resources. It is not a matter of how generous we want to be with veterans who served this country. It is a matter are we using those limited funds in the wisest way so the greatest and most needful treatment can be provided?

Mr. BAINE. That's right.

Mr. HUTCHINSON. The reason I asked you to look into—and may I say that I think in your report or in your testimony you made

very clear that you are presenting only options; that these are only suggested options that Congress might look at; that the issue of consistency and fairness to veterans across the country is paramount; that if you have one VA facility providing 47 percent of their prescriptions over-the-counter and another facility with 7 percent, I think that raises very serious questions as to whether veterans are being treated fairly and equitably, and those are things that in our oversight capacity we have got every reason in the world to look into and to be concerned about. Mr. Doyle.

Mr. BAINE. Could I make one comment, Mr. Chairman?

Mr. HUTCHINSON. Yes, certainly.

Mr. BAINE. And this goes back to a comment that you made just a few minutes ago.

As VA tries to decide whether through their network formularies—and they are headed toward, as I understand it, a national formulary for pharmaceuticals—as VA tries to decide whether to include or exclude over-the-counter products, it is almost a twofold decision. One is are you going to include them and provide them to the veterans essentially free of cost or free of charge? Or are you going to provide certain products; and then the decision is how much the veterans should have to pay. And that kind of goes back to the Ensure example. That is the best example I can think of. Are you going to provide this product, number one, and secondly, what is the extent to which the veterans would share in the cost of the provision of those kind of products.

Mr. HUTCHINSON. Thank you. Mr. Doyle.

Mr. DOYLE. Thank you, Mr. Chairman.

I just want to echo some of the comments made by my colleague Mr. Edwards.

I think one thing you have done today is highlight a significant issue when we talk about the inconsistencies from place to place and what OTC items are available. It is my understanding that, as you have just stated, that they are attempting to address this situation by establishing these networkwide formularies and ultimately a national formulary to make certain that the instances that the chairman spoke about are minimized, that we have some sort of standardization nationwide.

But, you know, I think what we want to keep in mind here is that the VA's medical care mission calls on it to provide medically necessary care and treatment to include supplies and services that the VA deems to be reasonable and necessary, and that the laws governing VA medical care draw no distinction between over-the-counter drugs or prescription drugs.

So the issue is as long as something is deemed to be medically necessary for the patient, I think it is totally appropriate that this include over-the-counter drugs as well as prescription drugs, and I don't think we ought to be deciding what over-the-counter drugs veterans are going to have access to or not have to pay for as opposed to prescription drugs. I think the guiding mission should be, is it medically necessary for the veteran. And as long as a doctor has decided that—whether it be Ensure or Tums or Tylenol or any other medication—that it is medically necessary in the treatment of that veteran, then that ought to be provided.

I think we also need to keep in mind, too, at least in my region, most of the veterans utilizing the VA medical facilities turn out to be veterans with low-income veterans that cannot afford treatment at other places, veterans without other types of hospitalization. And, when we talk about saving money, what we are really talking about is shifting these costs on to veterans. And that is a decision we need to make as a Congress. If we are going to shift these costs on to veterans, then we need to stand up and say that is what we are going to do.

But I think it is clear that there should be no distinction between prescription drugs and over-the-counter drugs so long as the doctor has deemed it medically necessary for treating the patient.

Mr. HUTCHINSON. Mr. Clement, you are recognized.

Mr. CLEMENT. Thank you, Mr. Chairman.

Mr. Baine, given that the VA's medical care mission calls on it to provide medically necessary care and treatment and to include supplies and services that VA deems to be reasonable and necessary, is it valid to hold the VA to the same standards as other health plans such as HMOs?

Mr. BAINE. That, in my view, Congressman, is a judgment that you are going to have to make. I think it is important to point out that the other health plans HMOs and so forth, that you cited in your question, do not preclude the use of over-the-counter drugs. Then you get to the question of who, in fact, pays.

In terms of the medically necessary quotation that you put forward, we had a conversation with people down at VA in terms of how VA itself is going to define "medically necessary," and I believe the short version of the VA answer is, it is up to the doctor to decide what is medically necessary. There is not really a definition.

And then you get to a situation which is somewhat analogous to the obviate the need for hospitalization, which is part of the eligibility requirements. This has not been all that well defined either. And that ends up being why various people raise questions about what is medically necessary, what is not; what will obviate the need for hospitalization, what will not; how soon would the hospitalization have to take place if you didn't take an aspirin a day.

Mr. CLEMENT. Mr. Baine, how do you respond to the VA concern that the discontinuation of over-the-counter drugs or undue restrictions on their availability could lead to increased visits, hospitalizations, or an overall increase in the drug budget?

Mr. BAINE. I guess I would respond, Congressman, by saying that it depends a lot on which over-the-counter drug products you are talking about. In other words, I don't think that many of the products that are included now in hospital formularies are the kinds of products that would, in their absence, require additional hospital visits. Some would. And I think that that is why as VA goes through the process of coming up with a national formulary and their network formularies and even at the medical center level, as they adjust their formularies, these are the kinds of things that need to be considered when these people are trying to decide which to include on their formulary and which to not.

Mr. CLEMENT. Mr. Baine——

Mr. REYNOLDS. If I could interject for a second.

Mr. CLEMENT. Yes.

Mr. REYNOLDS. We had suggested to VA in our discussions that they seemed to us to have all the answers to all of the difficult questions about the substitution of prescription drugs and the other difficult questions within their medical centers, because of the wide variation. In other words, they have a group of medical centers that are handling very few over-the-counters. And so it seems to us that if those haven't experienced a lot of problems and if it is working well for them, VA could determine it was prudent and economical, then it seems to us that they should model the rest after the ones that are less generous.

So basically, they have the data and the answers in their system, I think, because their medical centers have just about tried everything once and for some of them—there is some consistency.

Mr. BAINE. Congressman, one of the issues that we continually run up against as we deal with the VA health care system is that much of the information about any particular subject, and this is one of the subjects, is trapped at the medical centers. And so what we have tried to do, as part of the methodology for doing this particular assignment, is survey the medical centers to find out what they at least say they are doing. We are going to provide that information to VA. And hopefully, as we analyze the information and as VA analyzes the information, some of the answers that Paul was talking about will come to the surface and we can have a discussion with the people at VA and see if we can come up with some solutions.

Mr. CLEMENT. Mr. Baine, you commend the VA for its efforts to consolidate formularies. However, you claim that the VA has not yet achieved an adequate level of consistency or cost containment system-wide. How can this be improved?

Mr. BAINE. I think as VA goes through the process of developing, first, the network formularies and then the nationwide formulary and starts to make some tough decisions as to which products to include, which products to exclude, which products perhaps should go the canteen route it will be on the way to kind of getting to where it should be with regard to the over-the-counter products. Individual conscious decisions will be made on a whole array of products, whether to include them on the formulary or exclude them across the country.

Mr. CLEMENT. Thank you.

Mr. HUTCHINSON. Thank you, Mr. Clement. Mr. Bishop.

OPENING STATEMENT OF HON. SANFORD BISHOP

Mr. BISHOP. Thank you very much.

And let me welcome the panel. I, too, am a little concerned and want to follow up on what impact these proposals would have on the veteran.

As you know, and as has been stated earlier, a number of veterans are really on very, very tight budgets. Many are at the poverty level or below. And of course to increase copayments or decrease the dispensing of over-the-counter drugs will, if they get them, have to be paid by the veterans themselves.

I have a philosophical problem with placing more of a burden on veterans who have done their duty, who have responded when they were called, and now that they are in a position where they need

to call on the country to back them up and to make good its promise to them, that we are looking for ways to squeeze them. I have a problem with that.

And to contrast that, for example, if you remove or you limit the number of over-the-counter drugs, as someone pointed out, isn't it very likely that the patient/doctor relationship, physician/patient relationship that will develop or has developed in the VA hospitals, VA facilities, will cause the physicians, when they recognize that a patient cannot afford over-the-counter drugs, to dispense a prescription drug which will be paid for and at the same time, in order to address that patient's needs, which will inevitably be much more expensive than it would be had the over-the-counter drug been available for prescription by the physician? Isn't that true?

Mr. BAINE. I think you that, as I mentioned before, you will probably see some substitution of legend drugs for over-the-counter drugs that have been removed from the formulary for cost reasons.

As the medical centers and the networks and as VA tries to develop its national formulary and as the Congress decides how best the resources that are going to be provided to the VA for medical care should be spent, I think that what you are talking about, Congressman, are judgments regarding the best use of available dollars.

I think that our work has pointed out that there is some question, not with regard to all over-the-counter drugs but with regard to some of them, as to whether that is the best use of the VA dollar. And those are the kinds of judgments that I think the Congress is going to have to make and particularly the kinds of judgments that VA is going to have to make if its budget is going to be straight-lined for X number of years.

Mr. BISHOP. I grant you that we are charged with that responsibility and we have to make those kinds of judgments and we can't back up from them. But in the process of making those judgments, I think it is incumbent upon us to utilize common sense. And common sense tells us that if you have got a patient/doctor relationship and the patient needs some relief and the regulations don't provide it to be given one way, that the physician and the patient are going to figure out a way to get it within the breadth of those regulations. And it seems to me that that is not a common sensical approach to take if we know that that substitution is going to take place. It is not going to be cost-effective, and it is going to be an aggravation to everybody concerned, particularly to those of us who are trying to figure out logical ways to protect the budget.

Mr. REYNOLDS. One thing to make clear, I guess, is that not all over-the-counter products have prescription substitutes. So in looking at this, you would need to isolate the ones that had a prescription substitute from those that don't. And also, the 45 medical centers or the 45 pharmacies that reduced the number of over-the-counters over the last 3 years, they basically found what I would call a minor substitution problem. They ultimately, 6 of the 45, ended up adding some of the items back and they added a total of 20 items. So while it is true that substitutions are a potential problem, it doesn't appear, at least if those 45 are indicative of what would happen in the VA system, that it would be all that big a problem.

The key is the physicians, the key is the hospital director and the advice and guidance given to the physicians on how they want to get consistency.

Mr. BISHOP. The other concern I have, and my time is swiftly running out, is that if, for example, the doctors in the literature tells us that an aspirin a day does help prevent some catastrophic problems later on, if a veteran who is on a minimum income who doesn't get the best of primary care other than the veteran's facility, who doesn't necessarily get the best diet, the best food, if they have access to this, to the aspirin or to the over-the-counter drugs, wouldn't that ultimately save us money in the long run in terms of having hospitalizations for catastrophic, for the stroke or the heart attack or the whatever that is going to cost a bunch of money?

Mr. REYNOLDS. Yes, it would. Aspirin is one of those products where getting rid of it may end up costing money through hospitalizations. Aspirin is also an interesting answer to the first part of your question, which was what the effect would be on veterans from a monetary standpoint.

There are veterans now, the veterans who make the copayments, many of them would be better off buying the product from the open market because the price that they pay for the aspirin from VA is more through the copayments; it is more than off the open market. So for that group, they would actually not be hurt monetarily.

Mr. BISHOP. Why couldn't the VA reduce those costs and make it consistent with the market? I mean, certainly the VA is not in the business to make a profit.

Mr. BAINE. The issue there becomes an issue of handling, how much it costs VA per prescription filled to handle the product. And it is around $3 per prescription filled. The product cost is minimal. So if a veteran pays a $2 copayment for a 30-day prescription for aspirin, they are generally dispensed in, I believe, 90-day supplies so that is $6, you can get 90 aspirin for a whole lot less than $6.

Mr. BISHOP. Wouldn't it make more common sense to work on how to streamline that handling process rather than figure out how to take it out of the veteran's pocket?

Mr. BAINE. Yes. VA has worked on streamlining the handling process through their pharmacies.

So they have sort of worked on the efficiency end but you are still going to have fixed costs or a cost for the personnel involved in packaging these things up, getting them ready to mail and those kinds of things. And that is around $2.50 or $3 per prescription, I think.

Is that right, Paul?

Mr. REYNOLDS. Yes.

Mr. BAINE. So for a product like aspirin, where the ingredient cost is relatively minimal, the handling cost is the big part of what it costs VA to dispense the product.

Mr. BISHOP. If that product were dispensed by the VA facility itself, not the mail order, not the packaging, not the postage, not any of that but it was available to give to the veteran directly, that seems to me to reduce the price tremendously of handling. You reduce the number of hands that it has to pass through.

Mr. REYNOLDS. The VA pharmacies handle a bottle of aspirin the same way they handle the most expensive prescription drugs. They basically use one system, the same pharmacist and pharmacy technicians, the same quality control. And that is what drives the cost of handling up, as opposed to a private store which basically moves products from the loading dock through maybe one place to the shelves. So there is not nearly the handling.

Mr. BISHOP. Again, then, it seems like we need to address the handling problem, doesn't it? Doesn't that seem to make more sense?

Mr. BAINE. In some instances, I believe you are right, sir.

Mr. BISHOP. The retail establishments, if the retail establishments and the chains can handle it more efficiently, why can't the VA do that? Or why couldn't we develop the quality controls on that rather than taking it out of the veteran's package?

Mr. BAINE. That is an option. That is certainly an option just to eliminate the handling costs. But I think what you are going to find, if these things are dispensed through the pharmacy, the handling charge is going to be there. That is why I believe that some of the facilities across the country have turned this over to the Canteen Service, where the veteran could buy the product at a price that is less than they can buy it at a drugstore and VA eliminates the handling charge. Because what they end up doing is taking big bottles of these things and break them down into little bottles each step of which costs money.

Now, you might say that doesn't make a lot of sense, and I think I would agree with you. But I believe that that is why some of the medical centers have let the Canteen Service do this.

Mr. BISHOP. My final comment——

Mr. CLEMENT. I was going to ask the gentleman to yield a moment.

Mr. BISHOP. I will be happy to yield.

Mr. HUTCHINSON. There is no time to yield but go right ahead. Mr. Clement.

Mr. CLEMENT. I was just going to say, why don't we have some shelves in the waiting room and then they could take those aspirin right off those shelves and pay for it right there on the spot?

Mr. BAINE. One of the matters we mentioned in our statement is the possibility of doing this on a cash and carry basis. VA has been reluctant to do that because of copayment requirements and insurance requirements and so forth. But both, for these kind of products or particularly for these kind of over-the-counter products, it seems reasonable to have a cashier at the pharmacy and just do it. But for a whole lot of reasons, it is not being done.

Mr. BISHOP. It seems to me that, again, just trying to use common sense, these are the kinds of suggestions that I think a good management control process, a good task force, people who are experts in this could certainly, I think, address these kinds of concerns rather than just—it appears as if we are doing things the way have always been done, and because it has in the past cost $3 to handle it, we figure well, that is what it is going to cost when we ought to be looking at a better way to do it and that better way ought to be without having to again reach into the pockets of veterans.

If a retail establishment can sell it, certainly the VA should be able to sell it cheaper, because the VA is not trying to make a profit, and if they had it in waiting rooms, if they had a cashier there, if our part of it was reducing the necessity for copayments for over-the-counter drugs, that would be of benefit to the veteran but at the same time it would make that particular over-the-counter drug more accessible.

Now, if we need to do legislation to address that, you know, that is maybe something that we can look at. It seems to me that we ought to be looking at common sense ways to do it without stepping on the toes of veterans.

Thank you.

Mr. HUTCHINSON. Thank you, Mr. Bishop.

I have got several questions. On the cash and carry idea, currently do they bill every veteran?

Mr. BAINE. Yes.

Mr. REYNOLDS. Yes.

Mr. HUTCHINSON. That, in itself, is expensive, is it not?

Mr. BAINE. Absolutely.

Mr. REYNOLDS. Forty cents of every dollar collected.

Mr. HUTCHINSON. Forty cents of every dollar collected is in administration?

Mr. BAINE. Yes.

Mr. HUTCHINSON. And how much is never collected?

Mr. REYNOLDS. Twenty-five percent.

Mr. BAINE. It is 25 percent for the over-the-counter products, sir. It is a different percentage for the other medical services.

Mr. HUTCHINSON. Let's make clear also, as you did in your report, that what we are dealing with—I mean, you acknowledged in the report that there are certain over-the-counters that are essential to prevent a chronic or an acute case of being hospitalized. Aspirin was one you mentioned; insulin was another one. So we are really talking about those over-the-counters that may not—that medically it couldn't be argued that they would be prevented in that case.

You mentioned about, and I think it was Mr. Doyle that brought it up, quoted the mandate of the VA on providing that which is medically necessary, and I think you mentioned that surely that it has been doctors that define what is medically necessary.

But the fact is that when you are dealing with a limited budget, a global budget, you only have so much money to work with, somebody writes that formulary, and though the doctor may determine what is medically necessary somebody is defining, in some cases much more generously than in other cases, somebody is saying this is what we are going to provide. We are not saying we are going to provide everything for every veteran, as much as we might want to and our heart might say they deserve it because they served our country, ultimately, we are making decisions. Congress is in policy. The VA is in administration. And who is going to get what, whether they are going to get Ensure in one hospital or in one facility prescribed over the counter or in another place where they are not.

I mean, it seems to me that it is our job and our oversight responsibility and that is why we are even involved in this thing. We want the veterans to have this budget that we have got, whether

it is flat lined or whether we could somehow squeeze more, and I know this committee would like to get more into the veteran's budget. We have got to make sure that money is being used as wisely as possible. And if putting it into Ensure in one hospital or in one facility isn't the best way to use that money, then I think that is something we need to address. And if packaging and administration on billing is eating away at limited dollars, well then, we sure need to address it.

Mr. BISHOP. Will the gentleman yield?

Mr. HUTCHINSON. Absolutely.

Mr. BISHOP. I wholeheartedly agree with much of what the gentleman has suggested, but if you take, for example, if you use Ensure, for one patient in one particular circumstance, Ensure may be medically necessary. In that same facility for another patient, it may not be medically necessary. But for us to identify Ensure as a drug that we will or will not cover seems to me to be making the decision in the wrong place. That ought to be something that is between the patient and the doctor.

Mr. HUTCHINSON. Reclaiming my time, if it seemed to be under the current policy that a doctor could determine, wisely or unwisely, that this was medically necessary.

Mr. BISHOP. Right.

Mr. HUTCHINSON. And in one situation, it may be on the formulary and we would be able to provide it and in another one it not be on the formulary and not provide it regardless of what the doctor determined. It seems to me, if nothing else, we have got a big problem in consistency and the administration of the pharmacy program and we will be hearing that later.

Mr. BISHOP. Will the gentleman yield for just a second?

Mr. HUTCHINSON. Gladly.

Mr. BISHOP. That is another example of something that could be sold cash and carry and that would cut down on all of the administrative costs, all the copayments, all the things that we are talking about.

Mr. HUTCHINSON. Perhaps we can address that with the VA at a later—on the next panel.

The issue of those who are impoverished has come up. If I understand correctly, those who are impoverished do not pay a copay; is that correct?

Mr. BAINE. Yes.

Mr. HUTCHINSON. They don't pay a copay?

Mr. BAINE. That is correct.

Mr. HUTCHINSON. Those who are service connected disabled do not pay a copay?

Mr. BAINE. Those who are service-connected with a disability rating of more than 50 percent do not pay a copay.

Mr. HUTCHINSON. I think you said 47 percent of those receiving over-the-counter drugs are not service connected, do not have a service-connected disability?

Mr. BAINE. I believe that is correct, or at least were not being treated for a service-connected condition.

Mr. HUTCHINSON. Do we know how many of those are impoverished, how many of the about half that do not have a service-connected disability, how many of them?

Mr. BAINE. I can get that for you. We have it, but I can't remember the number at the moment, and I will be glad to get it for you, sir.

(Subsequently, GAO provided the following information for the record:)

GAO's assessment of the Baltimore pharmacy shows that 7,600 nonservice-connected veterans received OTC products during fiscal year 1995 and that 44 percent were exempt from the copayment requirements. To be exempt, a veteran must have reported to VA that his or her income was below $12,800 a year. VA does not maintain nationwide data on the number of nonservice-connected veterans who receive OTC products and are exempt from the copayment requirements.

Mr. HUTCHINSON. Did you find instances where it would have been cheaper for the VA to buy over-the-counter products for veterans in other local outlets than providing them through their pharmacies? It seems to me that in your report you indicated——

Mr. BAINE. I believe, yes. Yes, because—and that has primarily to do with the handling costs, the packaging costs, the mailing costs, and the billing costs.

Mr. HUTCHINSON. Okay.

Mr. BAINE. Those costs are fairly substantial when you are talking about a product like aspirin that you might pay 40 cents for a 90-day supply or VA might pay 40 cents for a 90-day supply. When you add the handling, that is where the real dollars are.

Mr. HUTCHINSON. Where they have adopted, and I may have asked this before but let me, since I don't remember the answer, where they have adopted a more restrictive formulary policy and they have used the canteen, or they have taken aspirin or Ensure or Tums and made those available at the canteen and taken them off the formulary, what has been the reaction of the veterans locally?

Now, I think you indicated that in some instances they didn't buy enough so they just took the product line off, but how has the—I don't know that you responded to what their attitude was toward having to use the canteen. Were there savings there such as that there was—what kind of reaction did we get?

Mr. REYNOLDS. We never talked to veterans about that but in our discussions with the medical centers, we gave them opportunities to express if there had been problems or if there had been such an outcry that they changed the policy or whatever and they never indicated to us that it was a problem or that they had tried it and it just didn't work so they went back. So the ones that tried it stuck with it, which would indicate that it must have been received fairly well.

Mr. HUTCHINSON. Chet.

Mr. EDWARDS. Thank you, Mr. Chairman. I will just briefly summarize.

I think this is a good hearing because I think there is going to be agreement that we need more consistency in the policy, and if there is agreement, that we need more efficiency in the purchasing of the products. And I think that is two areas.

The third area we are looking at, where there will be some differences of opinion that we will have to look at, is to what degree we want to make the policy decisions to restrict the sale of OTC products to our veterans.

So I appreciate the testimony. And it is healthy that we have policy debates, and I also think it is healthy that we find ways through this subcommittee to make our present policies more efficient so we can save dollars for our veterans. Thank you, Mr. Chairman.

Mr. HUTCHINSON. Thank you, Mr. Edwards.

Mr. Clement, do you have any additional questions of this panel?

Mr. CLEMENT. No.

Mr. HUTCHINSON. Mr. Bishop.

Mr. BISHOP. No.

Mr. HUTCHINSON. This is appropriate, since we have a vote, we will dismiss, with thanks and gratitude, this panel, and we have a second panel that we will call when we resume the hearing following this vote.

Mr. BAINE. Thank you, Mr. Chairman.

Mr. HUTCHINSON. Thank you.

[Brief Recess.]

Mr. HUTCHINSON. The hearing will resume.

The second panel is composed of Mr. John Ogden, the Director of the VA Pharmacy Service. He is accompanied by Mr. Leonard Washington, the Director of the VA Medical Center in Lebanon, PA; Mr. Cary Brown, Director of the VA Medical Center in Big Spring, TX; Mr. James Christian, Director of the VA Medical Center in Asheville, NC.

Selection of these directors was based on data from the GAO questionnaire. The formularies at Asheville and Big Spring were identified as thrifty, having controls on the number and types of the over-the-counter drugs and products dispensed by the hospital pharmacies. In contrast, the Lebanon Medical Center was identified as more generous in the provision of unique over-the-counter drugs and products dispensed to the patients.

I would ask each witness to summarize your testimony as the full text will be entered into the record.

Mr. HUTCHINSON. The chair now recognizes Mr. Ogden.

STATEMENT OF JOHN E. OGDEN, M.S., FASHP, DIRECTOR, VA PHARMACY SERVICE, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY: CARY D. BROWN, DIRECTOR, VA MEDICAL CENTER, BIG SPRING, TX; JAMES A. CHRISTIAN, FACHE, DIRECTOR, VA MEDICAL CENTER, ASHEVILLE, NC; AND LEONARD WASHINGTON, JR., DIRECTOR, VA MEDICAL CENTER, LEBANON, PA

Mr. OGDEN. Good morning, Mr. Chairman and members of the subcommittee. Rather than summarize, I think I will just read my statement, because it is fairly short.

I am pleased to have this opportunity to discuss VA's policies and practices on providing eligible veterans over-the-counter drugs, routine medical supplies and dietary supplements. The policy of the VA concerning the provision of any drug, including over-the-counter medications, medical supply or dietary supplement has been and remains to dispense these items if they are considered medically necessary for a patient enrolled in a treatment program. Over the years and for a variety of reasons, including budgetary, varied approaches have been employed by VA medical facilities in

dispensing these items within the spirit of this long-standing policy.

Mr. Chairman, during the latter half of 1995 and early 1996, VA took a number of multifaceted steps to enhance the systemwide management of drug expenditures and the distribution of these items. For example, we continued the expansion of our Consolidated Mail Outpatient Pharmacies, created a medical advisory panel, a national medical advisory panel, to guide the development of drug treatment guidelines for use throughout the system, continued emphasis on dispensing multimonth quantities to patients with chronic diseases, and directed the establishment of network drug formularies. We took these actions to enhance the economics of drug therapy and to achieve consistency in practice across the system.

Specifically, in regards to the discussion on network formularies, the Under Secretary for Health directed in September 1995 that each Veterans Integrated Service Network (VISN) establish a networkwide formulary by April 30, 1996. As a result, we moved from 159 individual medical facility formularies to 22 today. No later than May 1, 1997, we will have in place a national formulary. These actions will enhance efforts already underway to further standardize the goods and products utilized across the system. We also predict that these actions will have a positive, downward unit price impact on our pharmaceutical contracting efforts as marketplace competition in conjunction with the development of drug treatment guidelines intensifies for listing drug products on a network formulary or in the national formulary.

Because drug formularies serve as the compendia from which medication orders originate, the implementation of VISN formularies will provide a measure of consistency in dispensing policies and practices within a defined geographic area. The formularies will include over-the-counter products, routine medical supplies and dietary supplements. The evolution to a national formulary will ensure a measure of systemwide consistency in the provision of these products to eligible veterans.

In both instances, we recognize that formulary management is a dynamic and ongoing process. New products, new research and new treatment modalities foster a dynamic formulary process, including information like the type that is going to be provided to us by the General Accounting Office.

However, through the actions of our newly created Pharmacy Benefits Management (PBM) product line, we plan to utilize drug treatment guidelines to manage this dynamism and provide for the consistency mentioned above.

In September 1995, the Under Secretary for Health approved the establishment of the VA PBM. Organizationally, the PBM will include a small staff in VA headquarters, pharmacy subject matter experts at the Hines Hospital and a multitude of matrixes with other VA headquarters and field staff. The PBM's functions are to foster effective and efficient clinical drug use management; to identify and implement efficient and effective distribution systems for pharmaceuticals; also to develop a process, a continuous monitoring of the marketplace for bringing in best practices; and, four, to en-

hance effective management of the contracting environment for pharmaceuticals.

The two primary goals of the PBM are to foster the appropriate use of pharmaceuticals in the veteran population and a reduction in overall health care costs through the accomplishment of the four functions of the PBM.

Many times over the past 20 years there have been reports of inconsistencies among VA facilities in dispensing over-the-counter products. In the late 1980s, the Chief Medical Director reaffirmed the historic policy providing medically necessary items to veterans enrolled in a medical treatment program. In the recent past, we have received new reports that inconsistencies exist across the 22 networks. As I indicated earlier, the establishment of a national formulary will go a long way in eliminating such inconsistencies.

In addressing this issue—there has been at a lot of discussion on this this morning—we have to be careful that decisions regarding drug availability do not produce negative impacts. For example, the discontinuation of over-the-counter products or undue restrictions could lead to increased visits, hospitalizations or an overall increase in the drug budget if there is a shift in prescribing patterns. If we discontinued aspirin in total from the formulary, and a nonsteroidal, anti-inflammatory medication was prescribed in its place, a possible cost impact is an annual increase in expenditures of $2.2 million just for the ingredients, utilizing 1995 actual dispensing data and a low-price legend drug. Obviously this is a worst case example, but it is very clear that we would possibly incur greater expenditures if any shift in prescribing patterns occurred in the provision of medically necessary drug products to eligible veterans.

This next piece, I think, is very important as well. We currently expend less than 6 percent of our health care dollar for pharmaceuticals for both inpatients and outpatients. Of this 6 percent, approximately 10 percent is for the over-the-counter drug products for outpatients. That includes the medical, surgical and nutritional supplements. Thus, seven-tenths of 1 percent of our health care dollar is spent on over-the-counters. Private sector HMOs expend an average of 8 to 11 percent of their operating expenses for pharmaceuticals, primarily for outpatients. The low unit cost of over-the-counter items contributes to our favorable percentage and more integrated patient care because these dispensing actions are a part of the medical and pharmacy records.

In addition, the 1995 Ciba-Geneva Pharmacy Benefits Report on the managed care industry shows that 19 percent of staff-model HMOs provide over-the-counter products to their enrollees.

This data indicates that one in five staff-model HMOs have made the corporate decision that such policies are in the best interest of their enrollees and the health plan in general.

We think the prudent course for the Veterans Health Administration concerning the effective and efficient utilization of these items is the implementation of a well-managed approach to their utilization, not the wholesale elimination of them from our formularies. GAO has informed us, and we will be glad to do it, we will provide the data from the GAO to our 22 VISN formulary com-

mittees and encourage the adoption of best practices from other areas of the country.

Mr. Chairman, you also requested testimony concerning GAO's recent review of OTC usage in the VA. However, since we have not received their formal report, we cannot comment on it at this time. We would be pleased to provide our analysis of the report to the committee for the record.

In conclusion, our goal is to achieve best-value, quality health outcomes for our patients. I believe our efforts to provide consistency in the dispensing of over-the-counter medications, routine medical supplies and nutritional supplements through the development of a more systematic formulary process will be patient-responsive and contribute to cost-effective, best-value, quality health care.

Thank you for the opportunity to present testimony on this subject. We will be glad to address your questions. Thank you.

Mr. HUTCHINSON. Thank you, Mr. Ogden.

[The prepared statement of Mr. Ogden appears on p. 58.]

Mr. HUTCHINSON. Some day we are going to have these panels mixed. We are going to have GAO and VA all on there at once so you can respond to each other.

In your testimony, you stated that only 10 percent of drugs prescribed are over-the-counter. The GAO just testified that the percentage is much higher, standing at 25 percent. Could you comment on the difference?

Mr. OGDEN. That is 10 percent in cost, not in quantity.

Mr. HUTCHINSON. So what you are saying is that it is 10 percent in cost; 25 percent of the number of prescriptions is what GAO is saying?

Mr. OGDEN. They are saying 25 percent of the workload is over-the-counter drugs, yes.

Mr. HUTCHINSON. 25 percent—all right. Workload does count into cost; does it not?

Mr. OGDEN. Well, 10 percent of the cost—we are talking about cost of ingredients here. 10 percent of our drug budget of that 6 percent is for over-the-counter drugs.

As far as the workload goes, in regards to the number of prescriptions dispensed, somewhere between 20 and 25 percent of the workload is over-the-counter products, including medical surgical and nutritional supplements.

Mr. HUTCHINSON. Well, I would think, though, if we are going to talk about the whole issue here of efficiency and the best use of VA dollars, that if 20, 25 percent of the workload is over-the-counter, that that has to be—have a big impact on total cost, obviously.

In your testimony, you state that one in five staff-model HMOs provide over-the-counter products to their enrollees.

Mr. OGDEN. Yes.

Mr. HUTCHINSON. GAO's report runs counter to your testimony. Their research showed that HMOs are not likely to provide over-the-counter drugs except for insulin. Could you comment on that apparent discrepancy?

Mr. OGDEN. Well, I think it depends on the source of where they picked up their information. As I quoted in my testimony, my information came from the Ciba-Geneva 1995 trends in forecast reports

in regards to what is happening in managed care, particularly in managed care pharmacy. And there are other reports that show that 30 percent of staff-model HMOs provide some sort of over-the-counter benefit.

Mr. HUTCHINSON. So if they provided insulin, they would be, one—for instance, one over-the-counter, they would have been included in that 30 percent figure?

Mr. OGDEN. Right, right. I am not saying that these HMOs, whether they are a staff model or not an HMO, provide a total realm of over-the-counters. I am just saying that they provide over-the-counter accessibility to their enrollees as a part of their health benefit plan.

Mr. HUTCHINSON. I don't think there have been any who have argued today that there should be a total elimination of over-the-counter, only that there should be some consistency, and that there is—there are examples in the VA today where it is not a wise expenditure of dollars when we include Tylenol and Motrin and Tums on the formulary.

What is the date that the national formulary will be established?

Mr. OGDEN. No later than May 1, 1997.

Mr. HUTCHINSON. You used the word "evolution," that we are evolving toward a national formulary; that we have 22 now. We are going to have one in 1997. Explain to me why the delay. Why can you simply not establish—why do we need to take another year and a half to get there?

Mr. OGDEN. First, we just can't take a look at these issues in a vacuum. And probably one of the more important parts of this is to marry the contracting aspects of this to our strategic decisions regarding where we are going with the national formulary. And until we get the drug treatment guidelines developed and refined so we know where we are going inside a particular disease state, if you will, it is pretty hard to make a flat decision, if you will, on what drug items inside a certain therapeutic class we ought to keep or we ought to not keep. So that is why I say "evolution."

I think I also alluded in my testimony that a formulary, whether it is a network formulary or it is a national formulary, it is not a one-time situation. It is a dynamic, ongoing process.

And the GAO's comment, that there is a disparity across divisions in how they implemented their formularies, that is true, because what we told them in our directive from headquarters was not how to do their VISN formulary. We told them what to do in terms of creating a VISN formulary, expecting that the dynamics of moving from individual medical center formularies to VISN formularies, there was going to be some trauma. There was going to be some anxiety and some emotion because of the historic policy of each medical center having their own formulary.

But I think the evolution from a VISN formulary, as those VISN formularies continue to look inside therapeutic class and continue to refine what they will have on those formularies and not have on those formularies, once we make the decision on the national formulary, our job will be a lot easier because a lot of that blood, sweat and tears, if you will, will have taken place at the VISN level.

Mr. HUTCHINSON. I would think, though, that with the experience of the VA over the years with formularies, that you would have all the data in the world to work with on establishing a national formulary that another year, I don't——

Mr. OGDEN. Well, again--

Mr. HUTCHINSON. Certainly it is dynamic. It will be changing. It is not a set-in-cement thing, and certainly there is going to be some discomfiture when that transition occurs. But I don't see what—between now and next May, what additional data or information you are going to need.

Mr. OGDEN. Because when you start getting into some of these more difficult disease states, getting a consensus, coming to a consensus on developing these drug treatment guidelines is not very easy. It requires a lot of clinical input and a wide breadth of discussion before you make that decision.

On the other hand, we will take H2 antagonists, Tagamet, Zantac, names which we are all familiar with. We have already made the national decision that Cimetidine is going to be our number one H2 antagonist. We have a national contract, or will have shortly, and we are going to go out and bid the number 2 and 3 H2 antagonist, compete number 2, 3 and 4 against themselves, and basically have two H2 antagonists on our national formulary.

So what I am telling you is where we can make decisions now we will make them. We will move toward national contracts. Where it is more prudent to wait until the development of the drug treatment guidelines occur, we need to do that.

Mr. HUTCHINSON. GAO testified that on this whole cash and carry issue, that most VA facilities bill veterans for the $2 copayment rather than collect it at the time that the OTC products are dispensed. And they cited a VA-sponsored study that found that almost half of the $2 copayment collected pays for billing and collection costs.

Is billing an economical and prudent way for this to be done? Why does the VA not collect the $2 copayment at the time that the product is dispensed?

Mr. OGDEN. Well, in fact, I have been informed that about 35 percent of those copays for pharmaceuticals are collected at the time of the dispensing action at the pharmacy. Obviously, when we are dispensing products through the mail, that is another factor. We collect about $30 million a year in pharmacy copays, and so I think there is just a number of issues around this cash and carry issue of why we wouldn't collect the $2 copay right at the time of dispensing. Obviously, mailing prescriptions, and we do prefer mailing prescriptions where appropriate, does not allow us to collect the co-payment at the time of the dispensing action.

Mr. HUTCHINSON. What percentage is mailed? What percentage of prescriptions are mailed out?

Mr. OGDEN. I think nationwide, across the system, it is a little bit greater than 50 percent. It varies greatly between medical centers. Some medical centers may do 70 percent. Others will do less than 50 percent. Those are local decisions.

Mr. HUTCHINSON. And you are saying that systemwide 35 percent is now collected at the time that it is dispensed?

Mr. OGDEN. That is what I was informed, yes, sir.

Mr. HUTCHINSON. You don't dispute that where billing is taking place, that one-half of the copayment is lost in administrative and collection costs?

Mr. OGDEN. Well, I would have to look at the information that the GAO has provided.

Mr. HUTCHINSON. That was a VA study.

Mr. OGDEN. I would have talked to my folks in the VHA, as well as look at that GAO data before I could make a comment on that.

Mr. HUTCHINSON. On the 50 percent that is now currently mailed out nationwide, from the GAO testimony the policy of the VA is that all drugs are created equal. I mean, whether it is aspirin or whether it is some heart treatment or whatever, that packaged—all of the handling, all of the procedure is exactly the same, whether it is something that is very expensive to ship, like a liquid dietary supplement.

Does the VA have contracts with Fed Ex, or how is the mailing of—I know all of our offices have special rates that are given. Does VA take advantage of those kind of things?

Mr. OGDEN. We use a multitude of carriers. Obviously the United States Postal Service is a big part of our business in regards to mailing prescriptions. But I could tell you at our Consolidated Mail Pharmacies that we use a multitude of other carriers as well.

Let me backtrack a little bit and talk about a comment that Mr. Baine made concerning the doctor deciding what to prescribe. The doctor doesn't act in a vacuum. The doctor acts from a formulary that was created by peers, and, indeed, the doctor may be a member of that committee, so they are prescribing medications, whether it is Ensure or aspirin, what have you, based on the formulary that they clinically have determined to be medically necessary and the most appropriate to treat their patient population at their particular facility. So I think we need a clarification. It is not the doctor, it is the formulary committee.

Mr. HUTCHINSON. Well, given that, how do we explain one VA facility only having 7 percent of their pharmaceuticals being over-the-counter and another being almost half?

Mr. OGDEN. Well, again, I haven't seen that data, but my guess is—and I won't comment on the lower end, but on that higher end it could be a facility that primarily deals with spinal cord injury patients, and they may be dispensing a large amount of supplies associated with the treatment of those patients. And so I think that possibly could explain that 27 percent. But, again, I would like to see the data on that.

Mr. HUTCHINSON. Well, I think—who is it? Mr. Washington, I think it is your facility that was 47 percent. Do you have spinal cord injury?

Mr. WASHINGTON. No, I don't. I'm not aware of that percentage of being 27, but I don't have spinal cord injury patients.

Mr. HUTCHINSON. Well, that is what the GAO reported was that 47 percent was over-the-counter drugs. And so it is obviously not explained by spinal cord injury.

Mr. OGDEN. Can I say something else here? I would just like to insert that I have looked at the data in regards to our over-the-counter products that we dispense, by expenditure, and the top 82 percent of that $117 million that are the ingredient costs or

equates to the ingredient costs of over-the-counters, the top 82 percent, or $95, $96 million, basically are products for diabetes and conditions related to diabetes, or spinal cord injury patients, and for postsurgical patients. So—Ensure is in that percentage, and so are antacids. But even extracting those out, we are still talking 70 percent of the expenditure for over-the-counters is in those three areas that I just described to you.

Mr. HUTCHINSON. You mean those three areas, you are saying that Ensure and antacids are included?

Mr. OGDEN. Right.

Mr. HUTCHINSON. Then I would be curious what else is included.

Mr. OGDEN. Well, diagnostic strips, including the insulin test strips. Insulin and its affiliated products account for about $30 million of that $117 million, or approximately a fourth. Laxatives, enteral nutrients, antacids, bandages, dressings, urostomy, urinary collection devices, pads, diapers, syringes and needles, et cetera. In fact, the great percentage of those—those numbers I just discussed are in the area of medical surgical supplies.

Mr. HUTCHINSON. Thank you. I will yield to Mr. Edwards.

Mr. EDWARDS. Thank you, Mr. Chairman.

Mr. Ogden, let me ask you: Clearly, the cost of collecting copayment fees is high. It is a high administrative cost by most standards, and I guess we probably assumed it would be. I guess part of that idea is if something is totally free, then people might tend to abuse it like anything else that is totally free.

But do you see some problems if we were to refuse to give veterans OTC products when they came into a VA Medical Center, and they didn't have money on them? What problems, if any, would you see?

Mr. OGDEN. Well, again, as I indicated in the testimony, I think the issue of—I would like to separate the issue of the copayments from the clinical issue of taking care of the patient. And if the patient does not take the medication, whether we tell them to go buy it or we give it to them, if they don't take the medication, then the possibility of other episodes of acute care, ER visits, et cetera, would quickly overwhelm any savings we accomplished in regards to over-the-counter products.

Mr. EDWARDS. So one heart attack, it would take a lot of aspirin to pay for the cost of even one heart attack?

Mr. OGDEN. Well, I think there is another point I would like to make. There is one well-quoted study in the recent literature that says between $76 and $77 billion a year can be attributed to drug misadventuring in the American health care system. Now, a great part of that drug misadventuring is compliance with medications. And we have the problem—everyone has the problem—in treating patients, and so if we can't ensure that the patients are taking the medications, that they are compliant with their medications, when we are making clinical decisions on the next visit, and what have we done, what kind of quality value health care are we providing? So I think those kinds of concerns have to be brought into play as well.

Mr. EDWARDS. Let me ask you also, Mr. Ogden, in the GAO testimony, written testimony, there was a statement that we could be more efficient if we doled out larger quantities of drugs in order to

hold down costs. What are the problems there? There is a reason why we don't give a 12-month supply of drugs, over-the-counter or otherwise. Can we expand the kind of quantities we offer to a veteran without creating some serious problems?

Mr. OGDEN. That is a good question. Over the past 3 or 4 years, we have had a real consistent effort to encourage multimonth dispensing, and as I sit here today, the most recent data shows that systemwide, including all VA medical centers, we have about a 13 percent penetration in multimonth dispensing. For those VA medical centers that use multimonth dispensing, the penetration is 16.3 percent. And I think we are going to see a greater percentage continue to emerge over the coming years, and you are absolutely right. There are some products that could be dispensed in greater quantities.

But there is also another issue, and that is the stability of the drug product itself, and aspirin is a good example. I think we have to be careful, when we decide on multimonth dispensing, what drug products we do dispense, first off because of the stability of the drug, number one,; but number two, when you think about our patient population, the geriatric patient population, if the grandkids are around, and you have got these large bottles of medication sitting around, it is possible that something—a negative event could occur.

So I think, again, we are driving toward multimonth dispensing. It just needs to be done in a prudent manner, if you will.

Mr. EDWARDS. Could I also ask each of you, perhaps starting with Mr. Brown, if you could tell us how long you have had your policy in place at your medical center and how it has worked? In an objective fashion, if you could tell us what have been the pluses and what have been the minuses? If you could take 2 or 3 minutes each to summarize that, and maybe other Members will have deeper questions following up on that.

Mr. BROWN. Okay. At the Big Spring Hospital, we implemented restricting the formulary in 1989, and it is reviewed every month, the items that are on the formulary, both prescription and nonprescription, every month by the Pharmacy and Therapeutics Committee. And it seems to be working very well. I have been there 2 years, and I have yet to have a complaint on anything that is not on the formulary. Some things we restrict that are on the formulary as far as over-the-counter.

Mr. EDWARDS. How many products would you say you restricted, do you no longer provide, that are over-the-counter drugs?

Mr. BROWN. I wouldn't know.

Mr. EDWARDS. A large number, a small number?

Mr. BROWN. Medium numbers, I would say.

Mr. EDWARDS. Medium number. Okay. Thank you. Mr. Washington.

Mr. WASHINGTON. Me?

Mr. EDWARDS. Yes.

Mr. WASHINGTON. At Lebanon, we attempt to manage rather than preclude the prescribing of over-the-counter drugs so that our operating practice is to provide these agents to all eligible patients without regard to whether or not they are service-connected. We think that it makes the difference in keeping that patient in the

community. Therefore we support him with his medication and his nutritional supplement and medical supplies. In order to support the patient at home or in a community residence or a nursing home, we provide the diapers and the other supplies which makes a big difference in the cost of his care and in having the quality of life that that patient could enjoy. So we do that for patients.

Mr. EDWARDS. Thank you. Mr. Christian.

Mr. CHRISTIAN. Yes. Mr. Edwards. About 6 years ago in 1990, we began looking at our cost of medications. We were struggling, as all VA medical center directors do, with their budgets. We were most concerned because we saw an increase in the cost of prescription drugs and we wanted to have the right medications on our formularies, the most modern medications.

We felt that—our physicians ought to look at over-the-counter drugs, and our P&T committee decided to remove some of them from the formulary. We also decided to keep some OTC drugs on the outpatient formulary. We have OTC drugs on our inpatient formulary as well.

We decided to keep some drugs on our outpatient formulary, such as insulin, insulin syringes, colostomy/ostomy supplies, diapers and so forth.

The key thing was that our physicians were directly involved in determining what items went on the formulary and what items we took off of the formulary. Our experience has shown that patients have not complained significantly as they understand that we want to make sure that we can provide prescription drugs for them that they need most and foremost.

We worked hard on an education process to sell this concept to our veterans, and they have accepted it. Our physicians have also tried very hard in this effort to learn about our budget issues. They know that if a patient truly needs an over-the-counter medication that is not on the formulary, they can provide it, and they can do that by getting a countersignature by their superior. That gives them the opportunity to identify those truly needy veterans that they feel ought to be covered; that they get the OTC medications that they need, or in some cases there may be a 50 percent or greater service-connected veteran who feels very strongly that we should provide that to him. But there are many, many more service-connected veterans who are very grateful to have the prescription medications and also to share part of the costs of an OTC drug.

Over the last 5 or 6 years, we have saved $1.5 million, and that has helped us to make it. Our hospital is probably one of the lowest-cost hospitals in the system. Our indirect costs per episode of care shows only two or three hospitals that have lower costs than our hospital. So we have attempted to truly try to make sure that our care goes to—the most direct care services—to our veterans. And looking at the formulary also has been helpful to us in that regard.

We are looking at a $2.1 million shortfall next year based on the 1997 mark, so every $200,000 or $300,000 we save in a given year is going to help us continue to provide the programs and services and not cut back on the day-to-day services of our veterans. So we feel that this has worked at our facility. We most believe that by

involving our physicians in those choices and giving them options to those patients who have true need that we are able to meet the needs of our veterans and also deal with the budget exigencies that we have. Thank you, sir.

Mr. EDWARDS. Thank you, Mr. Washington.

Thank you, Mr. Chairman.

Mr. HUTCHINSON. Mr. Washington, what did you say was your policy at your facility on the distribution, prescribing of over-the-counters?

Mr. WASHINGTON. Our policy is that the physician determines—or the provider determines what medications or medical supplies or nutritional supplements the patient needs, without regard to whether the patient is service-connected or nonservice-connected. If there is a copayment that is required, the patient is expected to do that. But the physician determines the medical need for whatever the patient gets.

Mr. HUTCHINSON. But whether they are service-connected or not service-connected, is that in compliance with current eligibility rules?

Mr. WASHINGTON. That is in compliance. A person who is service-connected would get whatever the physician prescribed. If he were 50 percent or more, it is without copayment. If it is less, if it is for the condition for which he is service-connected, he gets that without charge. If he is nonservice-connected and he does not have the funds, he gets it. If he has a copayment responsibility, he is expected to do that. So there is no difference in the treatment. There is no violation of his eligibility. If he is eligible, he gets what we provide him.

Mr. HUTCHINSON. Is there a formulary?

Mr. WASHINGTON. There is a formulary at our hospital.

Mr. HUTCHINSON. But you said whatever the doctor felt was needed.

Mr. WASHINGTON. If it is on the formulary. I should have clarified that. If it is on the formulary, that is what the patient gets.

Mr. HUTCHINSON. Now, the result of that more generous policy is that 47 percent of what is being prescribed in your facility is over-the-counter.

Mr. WASHINGTON. That is a figure that I have heard, yes.

Mr. HUTCHINSON. How can—and, Mr. Christian, Mr. Washington, this is for both of you—how can Mr. Washington afford to have in his budget this very generous policy with regard to over-the-counter? And, Mr. Christian, you have stated that in order to meet your budget, you have found it necessary to have a more restrictive, more thrifty kind of approach. And I would like both of you to respond to that because I am absolutely perplexed as to how in the system we can have that kind of disparity.

What percentage—Mr. Christian, what percentage of your prescriptions are over-the-counter?

Mr. CHRISTIAN. I knew you were going to ask that. Mr. Chairman, I don't have that information. GAO may have it. I know that——

Mr. OGDEN. We can get that for you.

Mr. CHRISTIAN (continuing). We can get that information.

(Subsequently, the Department of Veterans Affairs provided the following information:)

The percentage for the VA Medical Center Asheville, North Carolina, over-the-counter prescriptions are 1.9 percent by dollar value.

Mr. HUTCHINSON. It was at the low end, I know.

Mr. CHRISTIAN. Yes.

Mr. HUTCHINSON. So I would assume they are probably down under 10 percent.

Mr. CHRISTIAN. Probably.

Mr. HUTCHINSON. Would you go ahead and respond?

Mr. CHRISTIAN. Mr. Washington and I have two different types of facilities. Mine is a tertiary teaching hospital affiliated with Duke. We have open heart surgery, a lot of complex cases coming into our hospital that have a lot of high-cost medications that we deal with. Mr. Washington's facility is different. I will let him explain that. But, you know, I think that each of our physician staffs have to look at the resources we have been given and try to determine what is best for our patients based on what services we are providing.

Mr. HUTCHINSON. Before Mr. Washington responds——

Mr. CHRISTIAN. Yes.

Mr. HUTCHINSON (continuing). In your opinion, will a national formulary work?

Mr. CHRISTIAN. Yes. I think—and our VISN is very actively involved in our VISN formulary, and just this month our chiefs of staff are going to be talking about OTC items on that formulary. And I think our model is being used by them to at least look at to see what can work and how we are going to go about doing it. But I do think that there has to be a degree of flexibility at all medical centers in terms of the programs and services they offer, related to specific types of care.

So some hospitals, to give you an example, Richmond, in our VISN, and Hampton are both spinal cord injury centers. They clearly are going to be dispensing more OTC items that deal with spinal cord injury patients than we would at Asheville. At a long-term care facility such as Mr. Washington's, they have different needs.

Mr. HUTCHINSON. Mr. Washington.

Mr. WASHINGTON. Yes. We have different patient populations, different hospitals. Ours has a more long-term care, chronic population. We, too, are affiliated, but our affiliation is much newer, and it is a much smaller affiliation than at Asheville. So we have patients who have chronic long-term needs, whose care we support in a number of different ways that does not necessarily include inpatient hospitalization. We maintain them in the community. We only refill patients' prescriptions for over-the-counter drugs for a chronic condition; that if it's a new condition, we give one refill—we give one prescription. It is not refilled unless the physician specifically identifies that this is a chronic need which needs to be refilled on a continuing basis.

Mr. HUTCHINSON. I would like to go on, but the committee is indulging their Chairman. So let me go to Mr. Bishop. You are recognized.

Mr. BISHOP. Thank you very much.

Let me go back to the multimonth dispensing and ask, isn't that a tool that physicians normally use, I should say infrequent—very infrequently use to make sure that patients keep their appointments? They dispense medication only for the period of time between appointments. Therefore, if the patient runs out of medication, he knows, well, I have got to go back to the doctor, I have got to keep my appointment because my medicine is running out.

If, on the other hand, you do multimonth dispensing, and the patient is still taking his medication, he may or may not be able to be sensitive to changes in the chemical makeup, for example, of his blood that would be indicative of something to the physician, but which the patient himself may not be aware of if he doesn't go back and have those tests at the doctor's office or the facility, I should say.

Is that not—would that perhaps result in some bad situations occurring if you do that multimonth dispensing?

And I add that I have had some experience with some multimonth dispensing for some sedative-type, addictive kinds of prescription drugs, from a veterans' facility where the care was not taken to determine whether or not the patient actually needed the multiple overdosing of some of the addictive medicines, and the patient ended up becoming very dependent and having to ultimately be separated from that. So I am asking if this is—is that not perhaps counterproductive?

Mr. OGDEN. Well, your point is well taken. The use of multimonth dispensing is an individual patient determination, and basically you would want to use that kind of attribute in patients with chronic, stable conditions as opposed to where there is a potential—where you need a dosage adjustment, you need to watch the patient more closely. That type of patient probably is not a candidate for multimonth dispensing.

So, again, the guidance that went out to the field was obviously to be prudent. The clinical concern for the patient is foremost when you make these decisions on whether we dispense multimonth quantities or not. And again I think that is reflective of the current penetration of 13 percent nationwide in the system. So I am not sitting here advocating that we go overboard with multimonth dispensing.

I think one thing we have done in conjunction with other actions regarding efficiencies and effectiveness is to change our policy. What we have done is a couple of years ago we changed the policy concerning the length of a prescription to allow prescriptions to be written for the original and 11 refills, which closely resembles most State laws in this country, excluding controlled substances, which the DEA has put a 6-month limit on. So we have changed the policy in regards to the duration of a prescription, which in essence, in theory, would reduce the number of clinic visits by 50 percent in those chronic, stable patients.

So when we talked about efficiencies and effectiveness, the only thing I wanted to say here was we shouldn't just take this over-the-counter issue and look at it in a vacuum. We have to look at it in total of what we tried to do and are trying to do. And the establishment of VHA's PBM is a very exciting development, and, if you remember, I said the goals of the PBM were the appropriate

use of pharmaceuticals and an overall reduction in total health care costs.

One of the things that is hard for a lot of people to comprehend is that we may actually expend more money on pharmaceuticals than we have in the past, but in reality our total overall health care costs will go down because—particularly as we move to primary care and the ambulatory care setting, pharmaceuticals are the primary tool of the health provider. It is a real possibility.

Mr. BISHOP. Let me just say, I was very, very interested in Mr. Washington's comments regarding what appears to be a more permissive, more liberal policy with regard to it, and it seems to be patient-centered, and it seems to be determined strictly by the patient's needs as determined by the physician. And apparently in the type of facility that you have, which lends itself really to a patient population that comes back repeatedly, that enhances their treatment to be close to the facility, as well as apparently to be close to home because it improves the quality of life, overall that seems to be a more positive response, conclusion for the veterans themselves, and I applaud that.

How does that compare cost-effectivewise with, for example, Mr. Christian? And I understand he has got a different kind of facility, but that is much more restrictive. What percentage of savings are you able to accrue overall with your policy as compared to the kind of savings that you have been able to—that Mr. Christian has been able to accrue?

Mr. WASHINGTON. I am not sure I can answer that. I can say that, for example, last fiscal year, we, with some changes in the formulary, reducing some of the duplicative items, that we had a $200,000 saving, and we anticipate that that saving would go forward into the future. With the network formulary, that there will perhaps be more savings, and with the national formulary, I would expect the same thing to continue.

Mr. BISHOP. But the more savings you have, the more likely you are going to touch on quality of life types of issues and satisfaction of services in terms of the veterans, though.

Mr. WASHINGTON. Well, the savings don't necessarily mean that services are being reduced to the veteran. I mean, we are reducing some duplicative medications and streamlining the formulary, but it doesn't mean that certain things that the veteran needs are not being made available to him.

Mr. BISHOP. Okay.

Mr. HUTCHINSON. Thank you, Mr. Bishop.

Mr. Tejeda, you are recognized.

Mr. TEJEDA. Thank you, Mr. Chairman. There were several questions which I had, but I have got a brief question. With a national formulary, what, if any, discretion will be provided to local physicians with regard to OTC products? If each one of you could answer to that, I would really appreciate it.

Mr. OGDEN. Well, I think from my perspective, I don't think it makes any difference whether it is an over-the-counter drug or a legend drug. There will be a nonformulary process—request process—put in place at the national level as well as at the VISN level, so that when you have those kind of idiosyncrasies in a particular patient, we will be able to address it. And the fact that we have

moved to just in time inventories, that we have a prime vendor in the pharmacy, you can make those adjustments. You don't have to have a large outlay for inventory costs because you could place the order for the drug this morning and have that drug on hand in a small quantity in the afternoon. So the nonformulary process will be effective at the national level just as it has historically at the individual facilities.

Mr. TEJEDA. Thank you, Mr. Chairman.

Mr. HUTCHINSON. Thank you, Mr. Tejeda.

I keep hearing about this we are going to go to the national formulary, and the national formulary is going to give us consistency across the system and——

Mr. OGDEN. A measure of consistency.

Mr. HUTCHINSON (continuing). A measure of consistency across the Nation, a measure lacking now.

But then I hear that each hospital, because it has a different constituency, needs to have a different formulary, and that the savings that Mr. Christian has been able to realize is because he had a more restrictive formulary. It seems to me that if you establish a national formulary that you go to the lowest common denominator; that in order to accommodate all the different constituencies and all the various facilities, you have to have the broadest kind of formulary which will mitigate any kind of savings of the kind that Mr. Christian has realized.

I don't know—Mr. Ogden, maybe you could respond to that.

Mr. OGDEN. Well, at least I will attempt to respond.

Again, I think don't look at this in a vacuum. I think the idea of developing drug treatment guidelines is a very positive step. That example I gave on the H2 antagonist is another good example of how we will be able to address the idiosyncrasies across individual medical centers but yet achieve some efficiencies from a national contracting perspective.

Mr. HUTCHINSON. Mr. Christian, would you respond?

Mr. CHRISTIAN. I would agree with Mr. Ogden. His H2 example is very strong. In our VISN, we are looking at that right now, irrespective of how the national policy come out. And we are hopeful we can save significant dollars and yet not decrease services to veterans at all who have gastrointestinal disorders.

Mr. HUTCHINSON. You have actually accomplished that, haven't you?

Mr. CHRISTIAN. We have not, not the H2 blockers. In fact, my pharmacist has presented that to me, and I have presented it on to my VISN network director, and it is going to be on the agenda for this month's chiefs of staff/council meeting at our local network. So we are looking at that very issue now.

We anticipate—and part of it is based on guidance that we hear from Mr. Ogden and others in the central office on where we are going in this regard. I don't think that you are going to see the wide variation if you have a VISN-wide formula. There will be patients in Richmond, as I gave in the example who will use items on that OTC item list that are on the formulary that we might not use in Asheville, and yet it will be on the VISN formulary.

Mr. HUTCHINSON. What about a national formulary?

Mr. CHRISTIAN. Same thing.

Mr. HUTCHINSON. The same would hold true?

Mr. CHRISTIAN. They will all be on there, but every medical center won't use every item. I mean, my guidance to my docs, who I have tried to educate them about the cost of medications and what it means, because I have told them if we don't control our budget and do the right thing for the patient, we are going to have to close beds or programs or services. And they don't want to do that. They don't want to let employees go.

Mr. HUTCHINSON. I thought your savings had resulted because with the cooperation of your doctors, you have a more restrictive formulary.

Mr. CHRISTIAN. Right, but the formulary at the VISN or national level may have items on it that they could choose to write for, but they don't necessarily have to write it.

Mr. HUTCHINSON. Then why have a restrictive formulary where you are at in your own facility if it is just—if you have just educated your doctors?

Mr. CHRISTIAN. That is a good question. I run the risk, once it gets on the formulary again, that they will write for it. But I think that I have made the educational transition, and I think it will make a difference. And I think as VISNs work together in making sure there is a degree of consistency across the hospitals particularly, in, say, our eight-hospital network, it is not going to be a problem, because if you duplicate that through the 22 VISNs, you are going to see consistency at a regional level and you are not going to have flack from different groups of veterans from X hospital or that hospital complaining about it.

We will have a VISN-wide formulary that we will try to implement. I think we will see some savings. The key thing is that when we consider high cost and volume items we save by looking at such things as those H2 blockers. It is the number one prescribed medication in my medical center, and if I can get cost efficiencies on that, I may save as much as a half million dollars in 1 year.

So we need to look very purposefully at the national formulary and try to decide what is going to be the best to do this, and that has merit. But I also think that at a VISN level you are going to have the flexibility at all hospitals to write some degree of differences, and that is why more than one item on the formulary would be good for multiple hospitals.

Mr. HUTCHINSON. Mr. Washington, what percentage do you mail out as opposed to——

Mr. WASHINGTON. I don't know the exact percentage, but I would suspect at least 60 percent of our prescriptions are mailed out.

Mr. HUTCHINSON. Mr. Christian?

Mr. CHRISTIAN. I am doing about 50 to 60 percent.

Mr. HUTCHINSON. Mr. Brown.

Mr. BROWN. I think ours is 50 percent.

Mr. HUTCHINSON. And would each of you respond to the suggestions of the GAO, one of the suggestions they made, that we do more of the over-the-counter and make that available in the canteens at discounted rates as opposed to the current practice of prescribing it?

Mr. Brown?

Mr. BROWN. Are you talking like aspirin, over-the-counter versus aspirin in the canteen?

Mr. HUTCHINSON. Well, I suppose that their recommendation would be that it would be up to the local hospital to decide, but that we take more of the over-the-counter, whether it is things like Tums and antacids to, you know, Tylenol and aspirin-type products, but more of those over-the-counter available in the canteen as opposed to treating them as they currently are, as any other prescription drug where you have the mailout costs, the handling costs, the administrative costs.

Mr. BROWN. Well, my interpretation of what they were saying, if it is an aspirin, over-the-counter item, that we do not provide it; we say to the patient, you should go to the canteen and buy it with your own money. That is what I interpret them to be saying, that it would not be bought out of the operating funds of the hospital, but they would go purchase it with their own funds. Therefore, we not only save the cost of the drug, but the mailing cost and the handling cost.

Mr. HUTCHINSON. And your attitude toward taking some of those currently on the formulary, the over-the-counter, and making them available in the canteen?

Mr. BROWN. No, not those items that are on the formulary. Those items that we determine to not be medically necessary.

Mr. HUTCHINSON. We have got things like Tums on the formulary. That's my point. Should some of those be taken off the formulary list and made available in canteens?

Mr. BROWN. The way we do it at Big Spring, if it is determined to be medically necessary, we provide it. If it is not determined to be medically necessary, then we do not provide it, whether it is on the formulary or not on the formulary.

Mr. HUTCHINSON. Mr. Christian.

Mr. CHRISTIAN. Okay. We do have Tylenol, Advil and so forth, at our canteen. Those items are not on our formulary. Veterans are told that they can get them there or they can go to K-Mart or wherever to get it. I think most of our canteens usually have a tremendous space problem and storage problem. They are only going to put things in their canteen that they feel that they can effectively sell and keep the Canteen Service going.

Mr. HUTCHINSON. Part of the savings you have realized is because you have less on the formulary list and——

Mr. CHRISTIAN. Yes.

Mr. HUTCHINSON.—they go out and find that at a retail outlet?

Mr. CHRISTIAN. Absolutely. We ask them to do that, ask them to share that cost and go out to wherever, just like when you go to your doc right now, he will say you need to take aspirin or Tylenol.

Mr. HUTCHINSON. Are there exceptions made if you have someone who simply cannot afford it?

Mr. CHRISTIAN. Absolutely.

Mr. HUTCHINSON. Mr. Washington.

Mr. WASHINGTON. Those items are on our formulary and are not available in our canteen, and it would be the clinical staff's advice, I am sure, that we not sell those things in our canteen. They want to be in control of all medication that a patient would take while

hospitalized and under their immediate care, so that it would not be available with their advice, I am sure.

Mr. HUTCHINSON. Mr. Ogden, if I could return to the multimonth dispensing issue, how do you define "multimonth"? Is that 90 days; is that multimonth?

Mr. OGDEN. 60, 90-day supplies, yes. In the case of some medical surgical items, they probably give out a larger quantity than that.

Mr. HUTCHINSON. My understanding is that VA physicians prescribe aspirin for most veterans on a 6-month or longer basis, but the VA does a 90-month dispensing—I mean a 90-day dispensing. It looks like there would be—on little things like that, there would be savings that could be realized if you went to the 6-month as opposed to 90-day.

Mr. OGDEN. Well, again, I think we can learn something from what the GAO has found in its survey because it is reflective of the practice that is out there in the system right now. But, again, I think those kinds of decisions on particularly drug products, in regards to dispensing quantities greater than 90 days, even 90 days, you know, the potential for some adverse event to take place, particularly with our population and their grandchildren, as I indicated before, that is another example.

But also important is the drug product stable for that—is the shelf life of the product good? We are not talking about potentially, you know, a vial sitting on the shelf that nobody opens it, but the cap could be left off. I mean a number of untoward things could happen. So I think we just have to be careful about that, and we could certainly look at quantities greater than 90 days.

Mr. HUTCHINSON. Mr. Bishop.

Mr. BISHOP. No thanks.

Mr. HUTCHINSON. I think we have about outlasted all of our colleagues. So let me thank the panel. We appreciate your testimony. I think there are some very important issues that have been raised about both consistency and efficiencies on the issue of over-the-counter, and I trust that as the entire GAO report is made available that you will be responsive to some of the issues raised. We will certainly be following this closely as well. Thank you very much.

Mr. OGDEN. Thank you.

Mr. HUTCHINSON. The subcommittee is adjourned.

[Whereupon, at 12:20 p.m., the subcommittee was adjourned.]

APPENDIX

Opening Statement
for
Honorable Chet Edwards
Ranking Member
Subcommittee on Hospitals and Health Care

Hearing on VA's Policies and Practices of Providing
Over-the-Counter Medications and Supplies

June 11, 1996
Room 334, CHOB

Mr. Chairman, as VA budgets fail to keep pace with inflation, it is particularly appropriate that we focus on opportunities to achieve greater efficiencies and cost-savings. I welcome an exploration into the feasibility of achieving savings in the VA pharmacy program, generally, and in provision of over-the-counter medical items, in particular.

Today's testimony questions certain medication dispensing and handling practices. It also appropriately questions a VA policy which has resulted in marked inconsistency in what medications and supplies veterans may receive from VA facilities.

I am encouraged that the VA's testimony suggests that it is making progress in establishing greater uniformity of practice.

GAO's testimony this morning raises provocative issues with respect to areas for cutting costs and cost-recovery in the provision of over-the-counter drugs and supplies. In particular, I note that GAO implicitly asks whether VA should even provide veterans with over-the-counter items.

In that regard, it's important to remember that the primary mission of the Veterans Health Administration is "to provide a complete medical and hospital service for the medical care and treatment of veterans". Current law authorizes VA to provide medically necessary care and services, including both treatment and "such other supplies or services as the Secretary determines to be reasonable and necessary." In short, VA is to provide veterans those items and services that are medically necessary.

As I understand it, the practical distinction between

"prescription" and over-the-counter medications and supplies is fundamentally one of WHERE and HOW a patient obtains them. An over-the-counter drug may be obtained without a prescription from any commercial outlet. But its ease of purchase does not mean that over-the-counter drugs as a class are not medically necessary.

Mr. Chairman, at a time of great sensitivity to the threat of Congress cutting benefits, I don't think we want to call into question the propriety of VA's furnishing ANY medically needed item, whether it's aspirin or an antibiotic. Achieving greater consistency from facility to facility is certainly important. Instituting efficiencies that minimize dispensing and handling costs should be encouraged. But I'm sure we don't want to make cost-savings or cost-recovery a higher priority than providing needed care and services to veterans.

United States General Accounting Office

GAO

Testimony

Before the Subcommittee on Hospitals and Health Care,
Committee on Veterans' Affairs, House of Representatives

For Release on Delivery
Expected at 10:00 a.m.
Tuesday,
June 11, 1996

VA HEALTH CARE

Opportunities to Reduce Outpatient Pharmacy Costs

Statement of David P. Baine, Director,
Health Care Delivery and Quality Issues
Health, Education, and Human Services Division

GAO/T-HEHS-96-162

Mr. Chairman and Members of the Subcommittee:

We are pleased to be here today to discuss the Department of Veterans Affairs' (VA) policies concerning its provision of medications, medical supplies, and dietary supplements that are available to the general public as over-the-counter (OTC) products in private outlets nationwide.

Under current law, two groups of medical products are available in the U.S. market: one group has about 65,000 products that are safe for consumers to use only as prescribed by a physician, the other group has over 300,000 products that, according to the U.S. Food and Drug Administration standards, are safe for use on the basis of a manufacturer's labeling alone. Prescription products are available only in licensed pharmacies, whereas other products are available over the counter in a wide variety of settings. OTC products are generally for conditions where users can recognize their own symptoms and levels of relief.

VA allows its physicians to prescribe OTC products primarily because VA physicians and others are concerned that veterans who need such products may lack sufficient resources to purchase them and, as a result, not use them. VA requires prescriptions as a way to control veterans' access to OTC products in VA pharmacies. Last year, VA physicians provided veterans with over 34 million prescriptions for pharmaceuticals, including OTC products, to be used on an outpatient basis. VA's 165 pharmacies filled prescriptions more than 65 million times, at a cost of almost $1 billion.

In recent years, VA officials have testified that resources are not sufficient to serve all veterans seeking care and that they expect such shortages to worsen in future years. Also, others have expressed concerns about the operating costs of VA pharmacies. Specifically, some have questioned whether VA pharmacies' provision of OTC products represents the most prudent and economical use of VA's available resources.

Based on these concerns, we have examined VA facilities' provision of these products for veterans' use on an outpatient basis and compared it with that of other health providers and insurers. Also, we have reviewed the financial aspects of VA's practices to reduce federal expenditures. My comments are based on information obtained from 149 VA pharmacies and discussions with officials in VA's 22 networks.[1] We also reviewed nationwide OTC product utilization data and obtained information from several headquarters offices, including the Pharmacy Service and the Medical Care Cost Recovery Office. At VA's pharmacy in Baltimore, we observed dispensing and copayment collection practices; reviewed

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[1]VA has 22 service networks, each consisting of between 5 and 12 facilities.

a wide range of records and documents; and discussed VA's provision of OTC products with 20 physicians, pharmacists, and administrators.

We discussed the results of our work with the Chief of Pharmacy Service as well as other VA officials. We plan to provide you with a report later this summer.

In summary, all VA pharmacies provide medications and medical supplies to veterans that are available over the counter through other local outlets. For example, VA pharmacies dispensed analgesics such as aspirin and acetaminophen almost 3 million times in fiscal year 1995. In other outlets, these analgesics are available through such OTC products as Excederin, Tylenol, Bayer Aspirin, Bufferin, and Goody's Headache Powders.

Each pharmacy offers a unique package of OTC products and some restrict which veterans may receive OTC products or in what quantity they may receive them. About one-third of VA facilities should be commended for taking actions to reduce the number of available OTC products in recent years. While others are considering reducing the available number of OTC products, about one-half are reluctant to take such steps. Network directors, to their credit, are working to achieve a level of consistency and cost-containment for facilities within their networks.

Unlike VA, other public or private health care plans cover few, if any, OTC products for beneficiaries. When covered, OTC products are generally made available on a uniform basis to all beneficiaries. These plans' coverage of OTC products is more restrictive than all but a few of VA's facilities.

VA pharmacies dispensed OTC products more than 15 million times last year, at an estimated cost of $165 million, including handling costs of $48 million. VA recovered an estimated $7 million through veterans' copayments, or about 4 percent of its total dispensing costs. Individually, veteran's costs varied, depending on the type of product and the veteran's eligibility status. Although many veterans shared a modest portion of the costs and some paid the full cost, most veterans paid nothing.

There are several ways that VA's resources devoted to the dispensing of OTC products could be reduced or revenues from copayments could be enhanced. First, VA staff could more strictly adhere to statutory eligibility rules. Second, VA could more efficiently dispense OTC products and collect copayments. Third, VA facilities could further reduce the number of OTC products available to veterans on an outpatient basis. Finally, the Congress could expand copayment requirements.

VA PHARMACIES PROVIDE AN ASSORTMENT OF OTC PRODUCTS

VA physicians prescribed OTC products for veterans more than 7 million times in fiscal year 1995, accounting for almost one-fifth of all prescriptions. VA pharmacies filled these OTC prescriptions over 15 million times, about one-fourth of all prescriptions filled.

VA physicians prescribed more than 2,000 unique OTC products. VA pharmacies classify these products into three groups: medications such as antacids, medical supplies such as insulin syringes, and dietary supplements such as Ensure. Medications account for about 73 percent of the 15 million OTC prescriptions filled, medical supplies for 26 percent, and dietary supplements for less than 1 percent.

VA Facilities Limit Physicians' Prescription of OTC Products

VA's network and facility directors have considerable freedom in developing operating policies, procedures, and practices for VA physicians and pharmacies. They and the pharmacies have taken a number of different actions to limit the number of OTC products available through the pharmacies and the quantity of products veterans can receive. However, little uniformity in the application of limits is evident.

In general, each facility has a Pharmacy and Therapeutics Committee that decides which OTC products to provide based on product safety, efficacy, and cost effectiveness. These products are listed on a formulary and VA physicians are generally to prescribe only these products.

Of the 2,000 unique OTC products dispensed systemwide, individual pharmacies generally handled fewer than 480, with the number of OTC products ranging between 160 and 940 products. Medical supplies account for the majority of unique products, with pharmacies generally dispensing fewer than 10 types of dietary supplements. However, three facilities' formularies excluded dietary supplements.

The volume of OTC products dispensed also varied among facilities. Overall, OTC products accounted for about 25 percent of all prescriptions filled systemwide. But OTC products represented between 7 percent and 47 percent of all prescriptions dispensed at individual facilities.

Of note, fewer than 100 products were involved in more than 80 percent of the 15 million times that OTC products were dispensed. The most frequently dispensed OTC products include (1) medications such as aspirin, acetaminophen, insulin, and stool softener; (2)

dietary supplements including Sustacal and Ensure; and (3) supplies such as alcohol prep pads, lancets, and chemical test strips.

Some Facilities Restrict OTC Products to Certain Veterans

Facilities have sometimes restricted physicians' prescriptions of OTC products to veterans with certain conditions or within certain eligibility categories. For example, 115 facilities restricted dietary supplements to veterans who required tube feedings or received approval for the supplement from dieticians. For medical supplies, a facility provided certain supplies only to patients who received them when hospitalized and another provided diapers only to veterans with service-connected conditions. One facility provided OTC medications only to veterans with service-connected disabilities.

Some Facilities Restrict Quantities of OTC Products

Facilities have sometimes restricted the quantities of OTC products that pharmacies may dispense. Twenty-eight facilities had restrictions, including limits on the quantity of OTC products dispensed within prescribed time periods or the number of times a prescription could be refilled. For example, one facility restricted cough syrup prescriptions to an 8-ounce bottle with one refill. It had similar quantity restrictions for 15 other OTC medications. Another facility had a no-refill policy for certain medical supplies, such as diapers, underpads, and bandages.

OTHER HEALTH CARE PLANS PROVIDE FEW, IF ANY, OTC PRODUCTS TO BENEFICIARIES

The Department of Defense operates a health care system for military beneficiaries, including active duty members, retired members, and dependents. This system provides a more restricted number of OTC products than most VA facilities. In 1992, Defense eliminated all OTC products except for insulin from its formularies to control costs. However, more expensive prescription medications were being substituted for some OTC medications that were no longer available. Subsequently, Defense reinstated a few products to its formularies to alleviate such substitution. All beneficiaries are eligible for OTC products without a copayment.

The Health Care Financing Administration directs the Medicare and Medicaid programs that pay nonfederal health care providers for medical care for target populations. Unlike VA, Medicare does not cover outpatient OTC medications for its beneficiaries. Like VA, Medicaid, at the option of the states, can cover OTC products for its low-income beneficiaries. The availability of OTC products varies by state, ranging from very few to a substantial array of products.

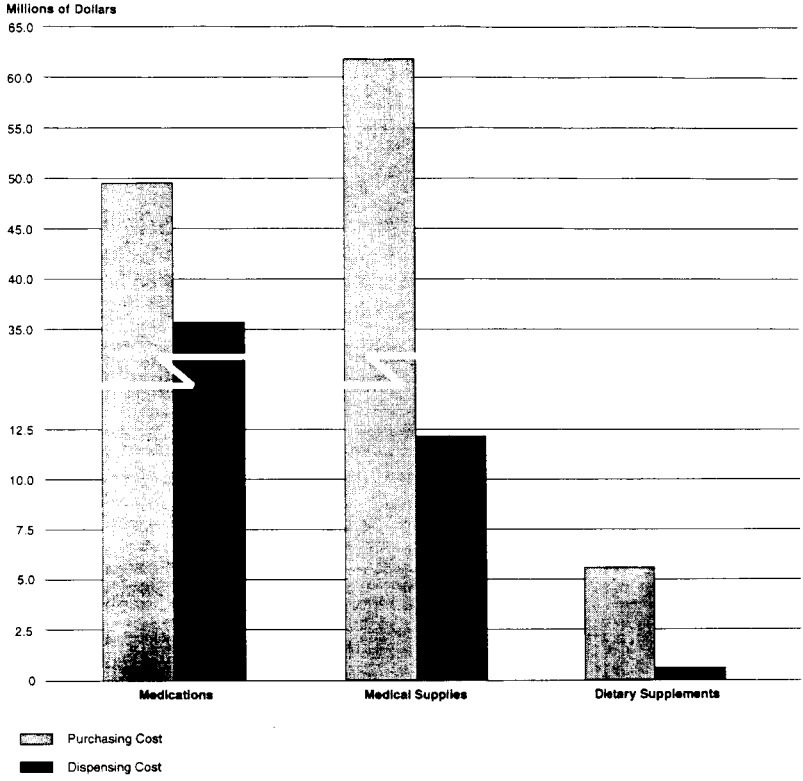
The Federal Employees Health Benefits program offers a range of health insurance plans to federal employees and their dependents. The program requires plans to meet certain minimal standards, which include prescription medications but no OTC products, except for insulin and related supplies. Blue Cross and Blue Shield and Kaiser Permanente are two of the larger plans and they cover no OTC products, other than insulin and related supplies. Both plans require beneficiary payments, with Kaiser charging $7 for each prescription provided in its pharmacy and Blue Cross and Blue Shield requiring a $50 deductible and 15 to 20 percent of individual prescription costs, depending on whether the beneficiary has a high- or low-option plan.

Finally, most private health insurers generally exclude OTC products as a benefit for participants, with a few exceptions such as insulin and insulin syringes. For example, the Group Health Cooperative of Puget Sound, in Seattle, provides insulin with a $5 copayment but no other OTC products. Before 1995, the Group Health Cooperative of Puget Sound did provide an OTC drug benefit. However, it dropped the OTC medication benefit because it found no other similar health plan that provided this benefit.

FEDERAL RESOURCES FINANCE MOST OF VA'S OTC COSTS

Nationwide, VA pharmacies spent an estimated $117 million to purchase OTC products and $48 million to dispense them to veterans in fiscal year 1995. Pharmacies spent about $85 million on medications, with purchasing cost representing about two-thirds of total costs. By contrast, they spent about $74 million for medical supplies and $6 million on dietary supplements, with purchasing costs accounting for most of these costs, as shown in figure 1.

Figure 1: VA Nationwide Estimated OTC Expenses (Fiscal Year 1995)



Purchasing and dispensing costs differ among the product categories for two reasons. First, VA physicians generally provide veterans more prescriptions for medications than supplies, thereby causing pharmacies to handle medications more often. Second, ingredient costs of medications are generally significantly lower than the cost of medical supplies.

VA recovered an estimated $7 million of these costs through veterans' copayments. By law, unless they meet statutory exemption criteria, veterans are to pay $2 for each 30-day supply of OTC medications and dietary supplements that VA provides. Veterans' copayments are not required for OTC products used to treat service-connected conditions. Also, veterans are exempt from the copayment requirement if they have low incomes.

Our analysis of veterans' copayments and pharmacy costs at VA's Baltimore facility shows that copayments offset no more than 12 percent of costs for medications, dietary supplements, and medical supplies, as shown in table 1.

Table 1: Comparison of Federal and Veteran Share of OTC Expenses, Baltimore Facility (Fiscal Year 1995)

	Medications	Dietary supplements	Medical supplies	Total
Federal funds	88%	99%	100%	93%
Veteran copayments	12%	1%	0%	7%

Federal funds financed most of Baltimore's OTC product costs. Copayments collected cover a relatively small portion of these costs, for several reasons. First, the $2 copayment collected for a 30-day supply represents only a portion of the ingredient, dispensing, and collection costs of most OTC medications and dietary supplements. Second, copayments are not required for medical supplies. Third, most veterans receiving medications and dietary supplements are exempted, and some nonexempt veterans do not pay copayments owed.

For individual OTC products, veterans' medication copayments ranged between 4 percent to more than 100 percent of VA's costs, depending on the type of OTC product and the quantities dispensed. For example, a veteran's medication copayment of $6 for a 90-day supply of an expensive product, such as the dietary supplement Ensure, may cover less than 5 percent of VA's costs ($400). By contrast, a veteran's copayment of $6 for a 90-day supply of an inexpensive medication, such as aspirin, may cover more than VA's total cost.

OPPORTUNITIES TO REDUCE FEDERAL EXPENDITURES

There is a variety of actions available that could help reduce the level of federal resources devoted to the provision of OTC products. First, if VA eligibility rules were more strictly enforced, VA pharmacies could dispense considerably fewer OTC products. Also, savings could be achieved through more efficient OTC dispensing and copayment collection processes. Finally, the Congress could expand the copayment requirements to generate additional revenues.

Federal Expenditures Could Be Reduced Through Stricter Application of Eligibility Rules

The Congress has limited VA's authority to provide outpatient medical care to veterans. Only veterans with service-connected conditions rated at 50 percent or higher are eligible for comprehensive outpatient care. All veterans with service-connected conditions are eligible for treatments related to those conditions; they are also eligible for hospital-related care of nonservice-connected conditions. This includes only outpatient services needed to (1) prepare for a hospital admission, (2) obviate the need for a hospital admission, or (3) complete treatment begun during a hospital stay. Most veterans with no service-connected conditions are eligible only for hospital-related outpatient care. VA is required to assess a veteran's eligibility for care based on the merits of his or her unique situation each time that the veteran seeks care for a new condition.

We have identified many instances in which OTC products are used for pre- and posthospitalization care. For example, veterans received OTC products, such as phosphate enemas, magnesium citrate, and prep kits needed for barium enemas in preparation for colonoscopies and other diagnostic tests. Following hospital stays, veterans received ostomy supplies after some surgeries, wound-care supplies, aspirin for heart surgery or angioplasties, and decongestants after sinus surgery.

VA has broadly defined the statutory criteria relating to obviating the need for hospitalization. Guidance to facilities says that eligibility determinations

> ". . . shall be based on the physician's judgment that the medical services to be provided are necessary to evaluate or treat a disability that would normally require hospital admission, or which, if untreated, would reasonably be expected to require hospital care in the immediate future"

In other words, VA physicians must determine that a veteran would likely need to be hospitalized soon if OTC products are not used.

Some OTC products may be used to obviate the need for hospital care. For example, diabetic veterans use insulin to control their blood sugar, spinal cord and Parkinson's patients use stool softeners to alleviate fecal impaction, veterans suffering renal failure use sodium bicarbonate tablets to balance their electrolytes, and veterans who have suffered heart attacks or strokes use aspirin to prevent secondary occurrences.

However, whether many veterans' conditions would require hospitalization in the immediate future without the use of other OTC products is not clear. Such products include antacids for heartburn, skin preparation products for dry skin, acetaminophen for arthritis pain, and cough medications for common colds. Given that VA pharmacies filled prescriptions for such products over 2 million times last year, VA facilities may have the opportunity to achieve significant cost reductions if eligibility rules are more strictly enforced.

VA's Costs Could Be Reduced Through Increased Efficiency

VA pharmacies could more efficiently dispense OTC products by reducing the number of times staff handle these items or restricting mail service. VA facilities could also reduce costs by collecting medication copayments at the time of dispensing.

Reduce OTC Product Handling Costs

VA pharmacies could significantly reduce their OTC product dispensing costs of $48 million by providing more economical quantities of medications and supplies. Dispensing larger quantities would reduce the number of times that VA pharmacists fill prescriptions for OTC products, saving about $3 each time the products would have otherwise been dispensed.

As previously discussed, VA physicians generally prescribe OTC products to treat acute or chronic conditions or prevent future illness. Prescriptions for acute conditions are generally for periods of 30 days or less. However, OTC products used for chronic or preventative situations are generally prescribed for longer periods. For example, in fiscal year 1995, about 1,800 veterans received aspirin at the Baltimore pharmacy in quantities sufficient for at least 6 months.

VA allows pharmacies to dispense most OTC products in quantities sufficient for a 90-day supply. However, 15 pharmacies currently dispense OTC products in 30-day or 60-day supplies. Moreover, limiting pharmacies to dispensing a 90-day supply is uneconomical for certain high-volume OTC products used to treat chronic conditions or prevent illness.

OTC products used to treat chronic conditions or prevent illnesses seem to provide opportunities to reduce dispensing costs. For example, we estimate that VA's Baltimore pharmacy could have saved over $8,000 in dispensing costs if it dispensed 180-day supplies of aspirin to certain veterans in fiscal year 1995. Assuming a prescribed usage of 1 tablet a day, this supply level of 180 tablets would be more consistent with the quantities available in local outlets, which generally range between 100 and 500 tablets.

Reduce OTC Mailing Costs

VA pharmacies could reduce dispensing costs by restricting the availability of mail service to certain situations or requiring veterans to pay shipping charges. Last year, VA pharmacies spent about $7.5 million mailing OTC products to veterans.

VA pharmacies generally encourage veterans to use mail service when having most prescriptions for OTC products refilled. Almost all pharmacies mail OTC products, and mail service was used for almost 60 percent of the 15 million times that OTC products were dispensed last year. Some pharmacies have already transferred most of their OTC prescription refills to VA's new regional mail service pharmacies and others will do so when additional regional pharmacies become operational.

While mailing costs vary, they can be particularly costly for liquid items or items that are dispensed in large packages or for long periods. For example, one facility reported that mailing a prescription of liquid antacids from the pharmacy costs $2.88 and mailing a case of adult diapers costs $17.49. Mailing costs for a year's supply of diapers could exceed $200. Some VA facilities cited high mailing costs as one of the principle reasons for eliminating OTC products from their formularies.

Several facilities have attempted to reduce mailing costs by prohibiting the mailing of certain OTC products, such as cases of liquid dietary supplements and diapers. In addition, some facilities reported switching from liquid products to powders to reduce the weight--and associated mailing costs--for particular OTC products.

Streamlining Copayment Collections

A third way to reduce federal costs is to streamline copayments for OTC products. VA primarily bills veterans for copayments, unlike other providers who generally require copayments to be made at the time that the products are dispensed. For OTC products dispensed to veterans in fiscal year 1995, VA's Baltimore pharmacy collected about 75 percent of the value of the copayments billed. The other 25 percent remained unpaid 5 months past the end of the fiscal year. The veterans who had not paid for these

products had not applied for waivers and, as a result, VA officials view them as able to pay.

VA facilities incur additional administrative costs to prepare and mail bills for copayments related to OTC products. VA facilities generally send an initial bill and three follow-up bills to veterans who are delinquent in paying. However, because of the relatively small outstanding balance for most veterans, VA officials told us that they are reluctant to continue contacting nonpayers or pursue legal or other actions to collect these debts. By law, VA has the option of not providing OTC products if a veteran refuses to make a medication copayment at the time the product is dispensed. VA officials, however, told us that it is not their policy to withhold OTC products from nonpayers for this reason.

Administrative costs are significant in relation to the total copayment collections. A VA-sponsored study estimated that VA facilities spend about 38 cents for every $1 collected to prepare medication copayment bills, mail them, and resolve questions. If the Baltimore facility's costs approximate this rate, it incurred an estimated $26,000 to collect $67,000 for OTC products in fiscal year 1995. In addition, about 25 percent of the medication copayments that were billed have gone unpaid and would have required additional costs to resolve. Collecting the copayment at the time a product is dispensed could eliminate most administrative costs and increase revenues.

VA Could Increase Restrictions on OTC Products

VA facilities could adopt less generous policies for OTC products, which would be more consistent with other health plans. This could be achieved by adopting such costs containment measures as (1) limiting OTC products available, (2) restricting veterans eligibility for OTC products, or (3) limiting quantities dispensed.

As previously discussed, each hospital offers a unique assortment of OTC products. For example, the most generous OTC product benefit packages contain about 285 medications, 514 medical supplies, and 14 dietary supplements. By contrast, the least generous packages include about 124 medications, 114 medical supplies, and 4 dietary supplements.

Over the last 3 years, 45 pharmacies have reduced the number of OTC products available to veterans. The most commonly removed OTC products are medications, such as soaps, skin lotions, and laxatives; dietary supplements, such as Ensure, multiple vitamins, and mineral supplements; and medical supplies, such as ostomy products and chemical test strips.

As part of VA's ongoing reorganization, the 22 network directors have developed an unduplicated inventory of OTC products dispensed by facilities operating in the network. In general, each network's formulary more closely approximates the more generous OTC product benefit packages available in each network rather than the less generous package. Some network directors plan to review their formularies to identify products that could be removed.

Recently, 58 facilities told us that they are considering removing some OTC products from their formularies. Most are examining fewer than 10 products, although the number of products under review ranges between 1 and 205. Products most commonly mentioned include dietary supplements, antacids, diapers, aspirin, and acetaminophen. Ninety facilities are not contemplating changes at this time.

Interestingly, wide disagreement exists about VA's provision of OTC products on an outpatient basis. For example, 22 facilities suggested that all OTC products should be eliminated. By contrast, 57 suggested that all OTC products should remain available. The other 70 facilities provided no opinion regarding whether OTC products should be kept or eliminated.

Many facilities pointed out that eliminating all OTC products could result in greater costs for VA health care. This is because some OTC products are relatively cheap or they help prevent significant health problems that could be expensive for VA facilities to ultimately treat. Also, facilities said that physicians may substitute higher-cost prescription medications in place of certain OTC products that would no longer be available.

Facilities reported 21 OTC products, which, if removed from their formularies, would result in greater costs to VA. Those most frequently mentioned were aspirin, acetaminophen, antacids, and insulin. These facilities also reported that 14 of the 21 products had prescription substitutes. These include aspirin, acetaminophen, and antacids (insulin has no prescription substitute).

While 45 facilities removed OTC products during the last 3 years, only 6 of them said that they reinstated some 20 products on their formularies. One facility stated that although it is commonly believed that limiting OTC medications would result in a higher use of more expensive prescription medications, it had not found this to be true at its facility.

As OTC products are removed from formularies, veterans will have to obtain the products elsewhere. To facilitate this, some VA facilities reported that they are using VA's Canteen Service to provide OTC products that have been eliminated from their formularies. The Canteen Service operates stores in almost every VA facility to sell a variety of items, including some OTC

products. For example, the Baltimore pharmacy has asked its Canteen Service store to stock about 13 OTC products that were recently eliminated from its formulary. The Baltimore pharmacy has already shifted most of its dispensing of dietary supplements to the store.

VA Canteen Service stores do not use federal funds to operate and generally provide items at a discount, in large part because they do not have the expense of advertising. By allowing these stores to dispense OTC products, VA may reduce both dispensing and ingredient costs for its pharmacies. At the same time, VA's Canteen Service stores can provide many veterans with a convenient and possibly less costly option for obtaining these products than would be available through other local outlets.

Expanding Veterans' Copayments for OTC Products Would Enhance Revenues

The Congress could reduce the federal share of VA pharmacies' costs for filling veterans' OTC prescriptions by expanding copayment requirements. This could be achieved through (1) tightening exemption criteria, (2) requiring copayments for medical supplies, or (3) raising the copayment amount. Unlike VA, other health plans' copayment requirements generally apply equally to all beneficiaries and for all covered products.

As previously discussed, veterans' copayments cover only 7 percent of the Baltimore pharmacy's OTC costs. If the copayment remains at $2 for each 30-day supply, changes that expand the number of veterans required to make a copayment could increase veterans' share up to 31 percent and thereby reduce the Baltimore pharmacy's share to 69 percent. A copayment of about $9 would be needed to achieve a comparable sharing rate if existing exemptions are maintained.

Restricting OTC Copayment Exemptions

When the Congress established medication copayments in 1990, veterans with service-connected disabilities rated at 50 percent or higher were exempt for any condition as were other veterans who receive medications for service-connected conditions. In 1992, the Congress exempted veterans from the copayment requirement for nonservice-connected conditions if their income was below prescribed thresholds.

Service-connected veterans received about one-third of the 116,000 prescriptions filled at the Baltimore pharmacy. Of these, almost one-half had ratings of 50 percent or higher. Veterans without service-connected conditions received the remaining two-thirds and about one-half of these veterans were exempt because of income below the statutory threshold. VA officials told us that while some low-income veterans may have difficulties with

copayments, most veterans did not seem to have such a problem before the 1992 enactment of the low-income exemption.

The Baltimore pharmacy could have recovered an additional 7 percent of its costs if all veterans without service-connected conditions were required to make copayments for OTC products; and an additional 11 percent of its costs if veterans were required to make copayments for OTC products provided for service-connected and nonservice-connected conditions.

Last month, VA's General Counsel recommended that VA facilities should use a more restrictive income threshold, as required by the 1992 low-income exemption. Earlier, we had informed VA's Counsel that facilities were inappropriately using the higher aid-and-attendance pension rate rather than the lower regular pension rate. Using the lower rate should allow the Baltimore facility, as well as other facilities, to collect large amounts of copayments from veterans who would not otherwise have been charged.

Requiring OTC Copayments for Medical Supplies

When the Congress established a copayment requirement for medications and dietary supplements in 1990, it did not include a requirement for medical supplies. VA officials told us that they know of no reason why medical supplies should be treated differently from other product categories in terms of copayments. Moreover, the legislative history of this 1990 action offers no explanation for why a copayment for medical supplies was not included.

Nationwide, VA pharmacies dispensed medical supplies about 4 million times to veterans in 1995, including about 36,000 times at the Baltimore pharmacy. Baltimore provided most supplies for 30 days or fewer, generally preceding or following a VA hospital stay. Many, however, were provided for longer-term conditions, including diabetic and ostomy supplies or diapers for those suffering from incontinence.

We estimate that the Baltimore facility could have recovered an additional 6 percent of its OTC product costs in fiscal year 1995 if veterans were required to make copayments for medical supplies used to treat nonservice-connected conditions.

Raising the OTC Copayment Amount

The Baltimore facility would need to charge a higher copayment to recover a larger share of its OTC product costs, if the exemptions and collection rates remain unchanged. For example, recoveries could be raised from 7 percent to 32 percent if the legislatively established copayment amount were $9 for a 30-day supply. However, if some changes are made to the exemptions, this

target share could be achieved with a smaller increase in the copayment rate, as shown in table 2.

Table 2: Estimated Copayment Recoveries as a Percent of the Baltimore Facility's OTC Costs ($1.1 million) for Different Exemption Options and Copayment Rates (Fiscal Year 1995)

	Medication copayment				
Options	$2	$3	$5	$7	$9
Existing exemptions	7%	11%	18%	25%	32%
Veterans with nonservice-connected conditions (before 1992)	14%	22%	36%	51%	65%
Veterans with nonservice-connected conditions (includes medical supplies)	20%	30%	50%	70%	90%
All veterans (includes medical supplies and veterans with service-connected conditions)	31%	47%	78%	109%	140%

CONCLUDING OBSERVATIONS

Most VA facilities offer an OTC product benefits package that is more generous than other health plans. In addition, VA facilities provide other features, such as free OTC product mail service and deferred credit for copayments owed, that are not commonly available in other plans. As a result, VA facilities have devoted significant resources to the provision of OTC products, which other plans have elected not to spend.

VA facilities could reduce their pharmacy costs if existing eligibility criteria are more strictly administered for OTC products. Less than half of the veterans receiving outpatient care have service-connected conditions. Thus, most veterans must meet the pre- and posthospitalization or obviating-the-need criterion. In our view, many veterans may be receiving OTC products for nonservice-connected conditions unrelated to a VA hospital stay or potential hospitalization. Toward this end, VA may need to provide better guidance to facilities to achieve an effective and consistent use of OTC products within its existing statutory authority.

VA should be commended for instructing network directors to consolidate formularies. This action, which is currently in progress, has not yet achieved an adequate level of consistency or

cost-containment systemwide because the networks current formularies approximate the more generous coverage of OTC products. Moreover, some networks are allowing facilities to have less generous coverage of OTC products than these networks' formularies. This will likely maintain the uneven availability of OTC products.

Given the disagreement among networks and facilities regarding the provision of OTC products, additional guidance may be needed to ensure that veterans have a consistent level of access to OTC products systemwide. In light of concerns about potential resource shortages at some facilities, tailoring the availability of OTC products to be more in line with those less generous facilities would seem desirable. This would essentially limit OTC products to those most directly related to VA hospitalizations or those considered most essential to obviate the need for hospitalization, such as insulin for diabetic veterans.

VA facilities could also reduce their costs if they restructured OTC product dispensing and copayment collection processes. In general, most facilities handle OTC products too many times, mail products too often, and allow veterans to delay copayments too frequently. Although, some facilities have adopted measures to operate more efficiently, all facilities could benefit by doing so.

Expanding veteran's share of the costs would also help to reduce federal resource needs. This could be achieved by expanding copayment requirements to include medical supplies, reducing the income threshold for veterans with nonservice-connected conditions, or increasing the amount of copayment required. In addition to enhancing revenues, such changes could also act as important incentives for veterans to only obtain the OTC products from VA facilities that they expect to use.

Finally, VA facilities have developed ways to provide OTC products to veterans outside their pharmacies at costs lower than they are available through other local outlets. Some facilities have had success using the Canteen Service stores to stock and sell OTC products that the facilities had removed from their formularies. This seems to provide a reasonable alternative to providing OTC products to veterans through VA pharmacies.

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Mr. Chairman, this concludes my statement. I will be happy to answer any questions that you or other Members may have.

For more information, please call Paul Reynolds, Assistant Director, at (202) 512-7109. Walter Gembacz, Mike O'Dell, Mark Trapani, Paul Wright, Deena El-Attar, and Joan Vogel also contributed to the preparation of this statement.

STATEMENT
OF
JOHN E. OGDEN, M.S., FASHP
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

JUNE 11, 1996

Mr. Chairman and Members of the Subcommittee:

I am pleased to have this opportunity to discuss VA's policies and practices on providing eligible veterans over-the-counter (OTC) drugs, routine medical supplies, and dietary supplements. The policy of the VA concerning the provision of any drug (including OTCs), medical supply or dietary supplement has been and remains to dispense these items if they are considered medically necessary for a patient enrolled in a treatment program. Over the years and for a variety of reasons, including budgetary, varying approaches have been employed by VA medical facilities in dispensing these items within the spirit of this long-standing policy.

Mr. Chairman, during the later half of 1995 and early 1996 VA took a number of multifaceted steps to enhance the system-wide management of drug expenditures and the distribution of these items. For example, we continued the expansion of our Consolidated Mail Outpatient Pharmacies, created a medical advisory panel to guide the development of drug treatment guidelines, continued emphasis on dispensing multi-month quantities to patients with chronic diseases and directed the establishment of network drug formularies. We took these actions to enhance the economics of drug therapy and to achieve consistency in practice across the system. Specifically, in

regards to network formularies, the Under Secretary for Health directed in September 1995 that each Veterans Integrated Service Network (VISN) establish a network-wide formulary by April 30, 1996. As a result, we moved from 159 individual medical facility formularies to 22. No later than May 1, 1997, we will have in place a national formulary. These actions will enhance efforts already underway to further standardize the goods and products utilized across the system. We also predict that these actions will have a positive, downward unit price impact on our pharmaceutical contracting efforts as marketplace competition in conjunction with the development of drug treatment guidelines intensifies for listing drug product(s) on a network or national formulary.

Because drug formularies serve as the compendia from which medication orders originate, the implementation of VISN formularies will provide a measure of consistency in dispensing policies and practices within a defined geographic area. The formularies will include OTC, routine medical supplies and dietary supplements. The evolution to a national formulary will ensure a measure of system-wide consistency in the provision of these products to eligible veterans. In both instances, we recognize that formulary management is a dynamic and ongoing process. New products, new research and new treatment modalities foster a dynamic formulary management process. However, through the actions of our newly created Pharmacy Benefits Management (PBM) product line, we plan to utilize drug treatment guidelines to manage this dynamism and provide for the consistency mentioned above. In September 1995, the Under Secretary for Health approved the establishment of the VA PBM. Organizationally, the PBM will

include a small staff in VA Headquarters, pharmacy subject matter experts at Hines Hospital and matrixes with other VHA Headquarters and field staff. Some of these organizational elements are the Office of the Chief Financial Officer, Chief Information Officer, Chief, Policy, Planning and Performance Officer, and the Chief Network Officer. The PBM's functions are (1) to foster effective and efficient clinical drug use management; (2) to identify and implement efficient and effective distribution systems for pharmaceuticals; (3) to develop a process for the continuous monitoring of the marketplace for best practices in pharmacotherapy; and (4) to enhance effective management of the contracting environment for pharmaceuticals. The two primary goals of the PBM are (1) to foster the appropriate use of pharmaceuticals, and (2) a reduction in overall health care costs through the accomplishment of the four functions of the PBM.

Many times over the past twenty years there have been reports of inconsistencies among VA facilities in dispensing OTC products. In the late 1980s, the Chief Medical Director reaffirmed the historic VA policy of providing medically necessary items to veterans enrolled in a medical treatment program. In the recent past, we have received new reports that inconsistencies exist across the 22 networks. As I indicated earlier, the establishment of a national formulary will go a long way in eliminating such inconsistencies.

In addressing this issue, we have to be careful that decisions regarding drug availability do not produce negative impacts. For example, the discontinuation of OTCs or undue restrictions could lead to increased visits,

hospitalizations or an overall increase in the drug budget if there is a shift in prescribing patterns. If we discontinued aspirin in total from the formulary and a non-steroidal, anti-inflammatory medication was prescribed in its place, a possible cost impact is an annual increase in expenditures of $2.2 million, utilizing 1995 actual dispensing data and a low-priced legend drug. Using a medium-priced legend drug, the impact would be an annual increase of $13.7 million. This example is worst case but it is very clear that we would incur greater expenditures if any shift in prescribing patterns occurred in the provision of medically necessary drug products to eligible veterans.

We currently expend less than 6% of our health care dollar for pharmaceuticals for both inpatients and outpatients. Of this 6%, approximately 10% is for OTC drugs for outpatients. Thus, 7/10 of 1% of our health care dollar is spent on OTCs, routine medical supplies and nutritional supplements for outpatients. Private sector HMOs expend on average 8 to 11% of their operating expenses for pharmaceuticals, primarily for outpatients. The low unit cost of OTC items contributes to our favorable percentage and more integrated patient care because these dispensing actions are a part of the medical and pharmacy records. In addition, the 1995 Ciba Geneva Pharmacy Benefits Report on the managed care industry shows that 19% of staff-model HMOs provide OTC items to their enrollees. This data indicates that 1 in 5 staff model HMOs have made the corporate decision that such policies are in the best interest of their enrollees and the health plan in general. We think the prudent course for the Veterans Health Administration concerning the effective and efficient utilization of these items is the implementation of a well-managed approach to their utilization, not the

wholesale elimination of them from our formularies. We will provide the data from the GAO survey to our 22 VISN formulary committees and encourage the adoption of best practices from other areas of the country.

Mr. Chairman, you also requested testimony concerning GAO's recent review of OTC usage in the VA. However, since we have not received their report, we cannot comment on it at this time. We would be pleased to provide our analysis of their report to the Committee for the record.

In conclusion, our goal is to achieve best-value, quality health outcomes for our patients. I believe our efforts to provide consistency in the dispensing of over-the-counter medications, routine medical supplies and nutritional supplements through the development of a more systematic formulary process will be patient responsive and contribute to cost effective, best-value, quality health care.

Thank you for the opportunity to present testimony on this subject. I and the accompanying witnesses will be happy to respond to your questions.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

ENCLOSURE I ENCLOSURE I

GAO'S RESPONSES TO POST-HEARING QUESTIONS

QUESTION 1
The GAO study identified five medical centers that dispensed the largest volume of OTC products. They are Iron Mountain, Michigan; Lebanon, Pennsylvania; Columbia, South Carolina; Castle Point, New York; Chicago (Westside). Why would these hospitals be able to support such a practice? Within their RPM group, do these particular hospitals have more resources available to direct toward the pharmacy which would allow them to be more generous?

GAO Response
Medical center directors receive an allocation of funds to operate their facilities. Each director has considerable flexibility in deciding how to use funds to meet veterans' needs. If a director has more than enough resources to meet all veterans' demands for care, then providing a large volume of OTC products is a discretionary choice which may be made. If a director does not have sufficient resources to meet all veterans demands, then a trade-off must be made between OTC products and some other services. Also, directors may sell excess medical services, such as specialized radiology, to other providers and use the revenues generated to provide other services to veterans, which may include OTC products.

The five medical centers identified had varying performance within their respective RPM groups. For example, the center in Castle Point was identified in the fiscal year 1995 process as a high cost center, while the center in Lebanon was considered low cost. The other three centers were considered neither high or low cost, but closer to average.

QUESTION 2
What are the most expensive items for VA to mail? How could VA save on mailing costs for heavy items such as liquids?

GAO Response
VA's mailing costs can be particularly costly for liquid items or items that are dispensed in large packages or for long periods. Among these items are cases of adult diapers and liquid dietary supplements as well as bottles of liquid antacids and cough syrup. To reduce mailing costs, some VA facilities have prohibited or restricted the mailing of certain bulky OTC products. Other facilities have switched from liquid to powder forms of dietary supplements in order to reduce the weight -- and associated mailing costs -- of these products. Facilities have also attempted to minimize costs by using fourth-class mail for some frequently mailed items. One facility has reduced the number of OTCs mailed by requiring veterans to pick-up commonly dispensed medications, such as aspirin, at the pharmacy window when these items are used

for short-term treatment.

QUESTION 3
On page 14 of your testimony, you informed VA that they were using the wrong income threshold, how much of an income difference is there between the aid-and-attendance rate and the base pension rate?

GAO Response
The difference in income between the two rates was almost $5,000 for 1995. For example, the aid and attendance pension benefit has an income threshold of $12,855 for a single veteran (i.e., with no other dependents). In contrast, the income threshold for the base pension benefit was $8,037. For veterans with one dependent spouse or child, the income thresholds increase to $15,345 and $10,527 respectively. For each additional dependent, the incomes increase by $1,368. Effective December 1, 1995, thresholds were increased by 2.6 percent.

QUESTION 4
Please describe the types and number of OTC medications and products provided by VA Medical Centers. What are the most common items prescribed?

GAO Response
In fiscal year 1995, VA dispensed more than 2,000 unique OTC products. Medications accounted for more than 1,100 unique products. The most commonly dispensed medications included aspirin, acetaminophen, insulin and docusate. Medical supplies accounted for more than 850 products. The most commonly dispensed supplies included alcohol prep pads, lancets, glucose test strips, and insulin syringes. Dietary supplements accounted for more than 50 products. The most commonly dispensed supplements included Ensure, Osmolite, and Sustacal.

QUESTION 5
You testified that veterans' copayments sometimes cover more than VA's costs. Did you find instances where it would have been cheaper for veterans to buy them in other outlets?

GAO Response
Yes. It would be less expensive for certain veterans to purchase generic enteric coated aspirin at their local outlets than to make copayments for it at VA. For chronic or preventative care, certain veterans generally pay VA a $6 copayment for 90 tablets of 325mg enteric coated aspirin. Annually, they would pay VA $24 for 360 enteric coated aspirin tablets. Four hundred tablets of the same aspirin would cost between $9.22 and $16.76 in the Baltimore area outlets. However, for less than $6.00 they could purchase 500 tablets of 325mg generic non-coated aspirin at the same outlets.

QUESTION 6
Please describe the policy of the Federal Employee Benefits Plan, the health plan which covers Congress and the federal government, with regard to over-the-counter drugs. Generally what is the policy on over-the-counter drugs that HMO's subscribe to?

GAO Response
The Federal Employees Health Benefits (FEHB) program requires participating plans to meet certain minimal standards, which include prescription medications but no OTC products, except for insulin and related supplies. This applies to participating fee-for-service and HMO plans.

According to the Health Insurance Association of America, most private sector employer sponsored health insurance plans, including HMOs, have a prescription drug benefit. However, these plans generally exclude OTC medications except for insulin and insulin syringes.

QUESTION 7
What could VA save annually if OTC drugs were eliminated? What does this number represent as a percent of VA's overall pharmacy budget?

GAO Response
In fiscal year 1995, VA spent an estimated $165 million to purchase and dispense OTC products. This represents about 13 percent of VA's total pharmacy costs.

QUESTION 8
Briefly explain the role of key players in determining the OTC benefit packages, dispensing OTC products, and collecting copayments?

GAO Response
VA's network and facility directors have considerable freedom in developing operating policies, procedures, and practices for determining the OTC benefit packages, dispensing OTC products, and collecting copayments. In general, they rely on a Pharmacy and Therapeutics Committee to decide which OTC products to provide based on product safety, efficacy, and cost effectiveness. This committee consists primarily of physicians. VA physicians are generally to prescribe only those products approved by this committee and only to those veterans eligible to receive them. Medical administrative staff help physicians determine veterans' eligibility and help determine which veterans' owe copayments. VA pharmacies stock approved products and dispense them to veterans, as prescribed by VA physicians. Medical Care Cost Recovery staff are responsible for collecting copayments owed.

DEPARTMENT OF VETERANS AFFAIRS

RESPONSES TO POST-HEARING QUESTIONS CONCERNING THE JUNE 11, 1996 HEARING ON OTC PRESCRIPTIONS AT VA FACILITIES

SUBMITTED BY HON. TIM HUTCHINSON, CHAIRMAN SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE HOUSE VETERANS' AFFAIRS COMMITTEE

Question 1: GAO testified that pharmacies are transferring mail service to newly completed regional mail service pharmacies. How would reducing OTC products affect the need to complete more regional mail service pharmacies? Is VA building one or more regional pharmacies solely to mail OTC products?

Answer: VA is not creating any consolidated mailout pharmacies (CMOPs) solely for the purpose of dispensing OTC products. A reduction in the provision of OTC products would, most likely, be of little significance concerning the need to create more regional mail pharmacies.

The system-wide scope of the CMOP project is affected by many variables. For example, increased outpatient prescription workload is occurring as a result of the shift from inpatient to outpatient care. In addition, as CMOP service expands, some of the original participating VA medical facilities are sending a greater percentage of their outpatient prescription workload to the CMOP. Even with increasing and ongoing implementation of multi-month prescription dispensing initiatives throughout the VA health care system, overall prescription workload continues to increase due to the shift in care delivery from inpatient to outpatient care noted above and the provision of health care services to a greater number of eligible veterans.

VA currently has four operational CMOP sites with two additional sites planned for operational status by October 1, 1996. These sites currently dispense approximately 30 percent of all VA mail prescriptions. CMOPs have improved customer service and efficiency by filling a larger volume of prescriptions with less manpower than individual facilities. In addition, we are exploring alternatives to enhance the distribution of medical/surgical items through alliances and partnerships with manufacturers and distributors.

Question 2: GAO report stated as part of its recommendations that VA should adhere more stringently to eligibility criteria in the dispensing of drugs. What guidance has been provided to the VISN directors and how is it monitored?

Answer: In addressing guidance and monitoring, facility directors and VISN directors are expected to ensure compliance with eligibility criteria for the dispensing of drugs as part of compliance with general eligibility rules. There is no Headquarters program for monitoring adherence to eligibility criteria in the dispensing of drugs.

QUESTION 3: GAO testified that there is wide variation in OTC benefits. Also, GAO said many facilities told them that they would prefer not to provide OTC products. Should VA have a uniform OTC benefit package? What steps do you plan to establish one?

Answer: In the provision of health care through VA's integrated health care delivery system, VA should have a uniform OTC benefit. Through the creation of VA's national drug formulary no later than May 1, 1997, and through the development and implementation of drug treatment guidelines as part of VA's Pharmacy Benefits Management product line, VA will create a uniform drug benefit, including OTCs. In the process of developing VHA's national formulary, VA medical centers and VISNs will be able to provide input and have their views expressed concerning the inclusion or exclusion of any drug or medical supply item on the formulary.

Question 4: Under VA's eligibility reform proposal, would all veterans be eligible for all OTC products?

Answer: Under our eligibility reform proposal, our policy would be to treat the whole patient and dispense medically necessary items, including formulary-listed OTC products to eligible veterans enrolled in a VA medical treatment program.

Question 5: Currently, GAO estimates that 25 percent of all VA prescriptions are for over-the-counter drugs and that prescribing of these items vary from 7 percent to 47 percent at the facilities surveyed. In your view, if the policy to supply over-the-counter drugs continues, what is an acceptable level for dispensing these items? Is 7 percent too low and 47 percent too high?

Answer: In reviewing internal data following the June 11, 1996 hearing, the range in prescription OTC workload varies from a low of 9 percent to a high of 39 percent. Because the needs of patients vary from facility to facility, it is very difficult to say if 9 percent is too low or 39 percent is too high. However, in the development of VHA's national drug formulary, we anticipate that (1) variances in the percentage of OTCs dispensed across medical facilities will decrease and (2) the number of OTCs on the national formulary will be less than some networks currently have and, in some cases, be greater than some networks currently have. Additionally, the development, deployment, implementation and monitoring of drug treatment guidelines will assist in standardization of utilization of all drug products.

Question 6: Understanding that the VA purchases huge volumes of over-the-counter drugs, what type of discount does the VA receive with volume purchasing?

Answer: In evaluating VA's volume discount for OTC products, we conducted a cost comparison of the top 25 VA generic products in the OTC class. In summary, VA prices ranged from 0 to 85 percent below the cost to various large buying groups and the drug wholesaler's average cost. The overall average was a VA cost of 35 percent below these private sector groups.

Question 7: If VA were to develop a policy that mandated the sale of over-the-counters at canteens, what would be your best estimate as to the personnel savings that could result (i.e., the elimination of handling, re-packaging, dispensing, and mailing such items)?

Answer: The GAO estimated that OTC handling costs, including personnel costs, amounted to $48 million in FY 1995 for OTC products dispensed from VA pharmacies. In theory, if these OTCs were sold from canteens, and VA medical facilities were prohibited from dispensing them, then some portion of the $48 million overhead cost would be avoided. However, there are a number of reasons why net savings of that magnitude would not accrue to the VA. For example, some OTC products could not be eliminated from the formulary even though they are classified as OTCs, e.g., insulin and diagnostic strips. In fact, 80 percent of the VA expenditures for OTCs used in FY 1995 were primarily for diabetic patients, spinal cord injured patients and post-op surgical patients. In addition, some degree of a shift from OTCs to legend medications would occur if OTCs were not available to providers as part of the formulary. Another factor is that lower income veterans may forego the purchase of an OTC on

their own and possibly become sicker and need more expensive care.

One of the positive attributes of VA's integrated health system, which the private sector is trying to emulate, is the availability of automated information regarding the patient's current and past pharmacotherapy. For this reason, deleting OTCs from the formulary would impact our goal to treat the whole patient and provide continuity of care. Therefore, for the reasons cited above, we can not estimate a possible reduction in overhead expenses for OTCs considered medically necessary in the treatment of a patient.

To The Hospital Directors:

Question 1: What is the current policy on controlling pharmacy costs? Does it vary from hospital to hospital and among networks?

Answers:

Asheville, NC, VA Medical Center

The Therapeutic Agents and Pharmacy Review Committee (TAPRC) and the Director of Pharmacy Service are responsible for reviewing medications requested to be added to and deleted from the formulary. This responsibility includes using the following criteria:

-- Diseases and conditions treated
-- Effectiveness
-- Therapeutic and/or pharmaceutical duplication
-- Acquisition cost and overall budget impact

In general, all VA medical centers attempt to control their pharmacy costs in the same manner.

Big Spring, TX, VA Medical Center

While policies vary among individual facilities, current policy at Big Spring VA Medical Center is that utilization of all pharmaceutical products is reviewed by the Pharmacy and Therapeutics Committee. Based on safety, efficacy and cost-effectiveness, the Committee is charged with providing pharmaceuticals necessary for the medical treatment of all eligible veterans. Monthly ongoing reviews address the appropriateness, safety, effectiveness and outcomes of pharmaceutical usage at the medical center. Cost containment for pharmaceuticals is also addressed through the facility's Cost Containment Committee, where cost savings, cost containment, and

cost avoidance are monitored, as well as the review of all reports pertaining to pharmaceutical usage from the National Center for Cost Containment.

Lebanon, PA, VA Medical Center

Lebanon VAMC uses a formulary system to control costs. Drugs are added to or deleted from our formulary based upon recommendations of the medical staff through the Pharmacy and Therapeutics Committee. Therapeutic agents that are deemed safe, efficacious and cost-effective are available to our prescribers in order to adequately treat our patient population. Until recently, each VA medical facility determined for itself which formulary agents should be employed. The creation of the VISN has resulted in more uniformity between hospitals within the VISN. A VISN Formulary Committee with representatives from each VISN medical center continues to refine the products that will be carried by all medical centers in the organization. This effort will be enhanced with completion of national contracts on core formulary products.

Question 2: As directors, how are you made aware of pharmacy costs? Is this something you follow on a weekly or quarterly basis? Is there a standard cost report sent into headquarters?

Answers:

Asheville, NC, VA Medical Center

Pharmacy Service provides a quarterly summary on the workload as well as the costs. My Director of Pharmacy Service works with the Fiscal Officer and Associate Medical Center Director on a monthly basis to inform them of the current cost of expenditures for pharmaceuticals.

Central Office receives Automated Management Information System (AMIS) reports from all VAs on a quarterly basis. This report contains workload reports as well as some cost data. This data is not as detailed as the information my Director of Pharmacy Service provides local management on a monthly basis.

Big Spring, TX, VA Medical Center

The Director at the Big Spring VA Medical Center is kept apprised of pharmaceutical costs through a variety of mechanisms. Budget hearings and management briefings are conducted twice yearly as well as monthly operational briefings with the Chief of Pharmacy. These meetings and a variety of reports prepared by the Chief, Pharmacy Service, serve as a forum to address cost issues related to pharmaceutical utilization. Pharmacy workload and expenditures are reported to headquarters on a quarterly basis through AMIS reports. Additionally, the National Center for Cost

Containment (NCCC) routinely accesses the Decentralized Hospital Computer Program (DHCP) data bases at individual facilities to extract and provide meaningful, comparative reports to VAMCs, VISNs and VACO concerning utilization of pharmaceuticals among facilities.

Lebanon, PA, VA Medical Center

As Director, I am made aware of pharmacy costs on a monthly basis. Pharmacy Service submits an annual budget, and once approved, this budget is managed and adjusted with monthly status of fund reports. Additionally, pharmacy submits a quarterly cost distribution report that headquarters receives through AMIS reports.

Question 3: How is the hospital formulary established? How much local control exists in the establishment of the formulary? What role does the Pharmacy and Therapeutics Committee play? In affiliated hospitals, what is the role of the medical school in the development of the hospital formulary?

Answers:

Asheville, NC, VA Medical Center

The Therapeutic Agents and Pharmacy Review Committee is responsible for establishing and maintaining a formulary for our medical center. Prior to the establishment of the VISN the medical center had total control in the establishment of the formulary. VHA Directive 10-95-111, Implementation of Veterans Integrated Service Network Formularies, dated November 7, 1995 (attached) removed much of the local control of formulary medications. Under the current process, all medications requested at the local medical centers for addition to their formulary must be submitted to the VISN Formulary Committee for final approval or disapproval.

Our medical center is affiliated with Duke University School of Medicine and we train between 30-45 surgical residents each year. The residents do not serve on the TAPRC as voting members but they can attend the meetings to speak to any request they might have concerning medications. The Committee is comprised of representatives from Surgery, Medicine, Psychiatry, Nursing, Pharmacy, Acquisition and Materiel Management, Ambulatory Care, Laboratory, Infectious Diseases, and a management representative.

Big Spring, TX, VA Medical Center

As a result of the reorganization within VHA, Veterans Integrated Service Network 18 (VISN 18) now maintains a single unified formulary for each member facility through the establishment of the VISN 18 Medication Management Board (MMB). The VISN 18 MMB

maintains the formulary providing the highest quality patient care, eliminating therapeutic duplication, and promoting competitive purchasing contracts. Member facilities may develop and implement formulary policies and procedures which provide more strict structure and control than those set forth by the MMB; however, they may not institute more lenient policies and procedures. The MMB considers requests for formulary modifications upon the recommendation of a VISN 18 facility's Pharmacy and Therapeutics Committee.

The Pharmacy and Therapeutics Committee at the Big Spring VA Medical Center accepts recommendations for changes to the formulary from all providers credentialed and privileged to prescribe medications at the medical center. This includes physicians with teaching appointments at the affiliated medical school. Several of the members of the Pharmacy and Therapeutics Committee are actively involved in the academic affiliation through teaching and advisory roles.

Lebanon, PA, VA Medical Center

Our hospital formulary is established by a local committee which subsequently submits recommendations to the VISN Formulary Committee. Our local committee is vital in seeking the "Best Buys" among products of a general class of drugs. Our affiliation with Hershey Medical Center provides some stimulus for formulary selection, but the final decision is made exclusively within VA.

Question 4: What was the total cost to your medical center of providing over-the-counter drugs and products? What was the increase from FY 1994 to FY 1995? And what do you project for this fiscal year? Of this total, what dollar amount was for mailing or postal fees?

Answers:

Asheville, NC, VA Medical Center

During FY 1995 the costs of providing over-the-counter medications to outpatients was less than $3,000. The costs of providing over-the-counter supplies was around $119,000. These items included one-touch diabetic strips ($41,000), diapers ($10,500), bandages, tape, duo-derm dressing, gloves, etc., ($9,700), catheters ($2,300), tube feeding products ($8,000), ostomy supplies ($36,000), IV tubing ($1,000), etc.

We do not provide Tylenol, aspirin, antihistamines, cough and cold medications, Mylanta, topical creams, lotions, ointments, and similar type medications.

There was very little increase from 1994 to 1995, but we expect to see an increase of about $30,000 to $40,000 during 1996. This increase is primarily due to a shift in home antibiotic therapy (IV tubing and supplies), early discharges from the medical center (gauze pads, tape, catheters, etc.), and an increase in discharge with patients receiving tube feedings.

Postal fees for over-the-counter medications and products provided by our pharmacy during FY 1996 will be around $1,500. Postal fees for over-the-counter medications and products during FY 1994 and FY 1995 were between $1,200 - $1,300.

Big Spring, TX, VA Medical Center

It is estimated that the VA Medical Center expended approximately $74,000 for FY 1995 for over-the-counter drugs. Expenditures for FY 1994 are estimated at $73,000, with $74,000 projected for the current fiscal year. Postal fees for over-the-counter drugs at this medical center are very small because of the use of alternative delivery systems, and the formulary refill restrictions. Estimated postal costs for FY 1994 are $1,050, for FY 1995 are $1,110 and projected for the current year at $1,000. Alternative delivery systems have included delivery of medications utilizing the network of transportation services provided by Veterans Service Organizations, utilization of multi-month dispensing to avoid refills, coordination for delivery through our Social Work Service when home visits are made, utilization of the associated Readjustment Counseling Center as a delivery point, and home delivery by other VA Medical Center staff.

Lebanon, PA, VA Medical Center

In FY 1995, $582,177 was spent on OTC products. This includes OTC drugs, medical supplies, and nutritional supplements. This constitutes approximately 11 percent of our total pharmacy budget. Data is not available for OTC purchases for FY 1994. However, applying 11 percent to FY 1994 shows approximately $506,861 was spent on OTC products of all categories. Projections for FY 1996 indicate approximately $656,000 will be spent on OTC purchases.

Mailing costs determined by weight, for all products in FY 1995, both prescription only and OTC, totaled $126,000. It is impossible to calculate OTC vs. prescription-only mail costs since both types of products are frequently mailed in the same package. Data reveals 27 percent of all items mailed from our pharmacy are OTC; however, the weights of some OTC products exceed those of prescription-only drugs. Therefore, it can safely be assumed that 30 percent or more of mailing costs are generated by OTC products. Applying 30 percent to FY 1995 mailing costs shows approximately $37,857 was spent mailing OTCs.

Question 5: What is your opinion of over-the-counter drugs? Do you think they should be completely eliminated? What would be the drawback if eliminated?

Answers:

Asheville, NC, VA Medical Center

Elimination or reduction of over-the-counter medications and supplies provided by the VA can reduce pharmaceutical expenditures. In 1990 and 1991 our medical center stopped providing most of these medications to outpatients. The Therapeutic Agents and Pharmacy Committee (TAPC) felt that certain medications and supplies should be provided to the patients even though they were over-the-counter. The medications and supplies we continue to provide to patients are: insulin and syringes, glucose test strips, tube feeding, diapers, catheters, gauze pads, tape, and ostomy supplies.

During the past five years our medical center has saved approximately $325,000 each year by not providing these over-the-counter medications and supplies. This saving was from cost avoidance in drug acquisition, labor and mailing costs. We have not seen any major negative outcomes by not providing the other OTC medications and/or supplies.

Big Spring, TX, VA Medical Center

Some over-the-counter drugs, such as insulin, play a crucial role in the medical treatment of patients, while others may not be essential to quality patient care. Because of this fact, the effective and efficient utilization of over-the-counter pharmaceutical items is essential in the treatment of eligible veterans. Wholesale elimination of over-the-counter drugs would eliminate treatment choices for physicians and could shift prescribing patterns causing an actual increase in prescription drug costs as well as increased visits and hospitalizations.

Lebanon, PA, VA Medical Center

It is my opinion that a drastic reduction in provision of OTCs will increase demand for more expensive prescription-only products. In addition, VA would lose the ability to monitor use of OTC drugs by patients which might complicate therapeutic decisions. It is believed by our medical staff that appropriate use of OTC products helps obviate the need for more extensive care to include hospitalization.

Question 6: Because over-the-counter drugs are largely convenience items, are they added to the formulary at the request of the individual veterans or VSOs?

Answers:

Asheville, NC, VA Medical Center

Many of the over-the-counter medications are medically necessary and are not "largely convenience items." Our TAPRC reviewed the OTC status in late 1990 and determined that elimination of specific medications and supplies from the formulary would allow us to shift some of the cost and responsibility of the medications to patients. The medication costs avoided, manpower avoided, and mailing cost avoided has been used to provide medications and pharmacy services to approximately 150 additional veterans for the past five years.

Neither the individual veteran nor the VSOs participate in the formulary process at this medical center.

Big Spring, TX, VA Medical Center

Over-the-counter drugs have been determined by the Food and Drug Administration to be safe and effective for self-treatment of certain conditions. While some items may be convenience items, many are essential to quality patient care. The formulary status of all pharmaceutical items, at the medical center, is based on safety, efficacy, and cost-effectiveness of the product with the request for addition of pharmaceutical agents to the medical center formulary coming from physicians with prescribing privileges.

Lebanon, PA, VA Medical Center

OTC products are provided only upon the order of the health care provider. Decisions to add or delete individual items are made by our Pharmacy and Therapeutics Committee in response to requests by providers and not individual veterans or Veterans Service Organizations.

Question 7: How does your medical staff find out about new drugs? How is access by pharmaceutical salesmen or detail men controlled at your medical center?

Answers:

VACO Pharmacy Service

Regarding over-the-counter drug products, most, if not all, pharmaceutical companies do not market OTCs during their visits to or display time at a VA medical center. In talking with a number of pharmaceutical companies about this issue, they informed me that their efforts are directed toward educating

medical staff about the merits of legend drug products. Their general feeling is that OTCs do not need marketing and there is no return on investment to the company in marketing them.

Asheville, NC, VA Medical Center

The medical staff at our VA finds out about new medications through journal articles, reviews, and advertisements. Pharmacy Service coordinates a drug display on the second Wednesday of each month at which eight to ten pharmaceutical sales representatives attend. Physicians, nurses, pharmacists, dentists, PAs, and dietitians attend these drug displays. Physicians also see pharmaceutical sales representatives by appointment.

Access to the medical center by pharmaceutical sales representatives is controlled by Acquisition and Materiel Management Service (A&MM), and Pharmacy Service through a sign-up program. Neither A&MM nor Pharmacy Service is involved in making appointments for the pharmaceutical sales representatives to see physicians.

Big Spring, TX, VA Medical Center

As new drugs are approved by the FDA, unbiased information concerning that drug is provided to all physicians by the Pharmacy Service in the form of a news bulletin. The Pharmacy Service also provides drug monographs to all clinical services on selected drugs. Physicians have opportunities to attend clinical staff lectures and grand round programs which address current treatment recommendations. At the Big Spring VA Medical Center, the hospital policy restricts pharmaceutical detailing to designated areas and dates. Other contact between pharmaceutical representatives and physicians is prohibited at the medical center.

Lebanon, PA, VA Medical Center

Information regarding new drugs is obtained through continuing education, medical seminars, professional literature, and drug company representatives. Access for drug company representatives is controlled by our Chief of Pharmacy. Access badges are issued on a one-visit only basis. Detailing of drugs is limited to formulary products. New products may be explained but drug representatives are instructed to convey to providers that the product is non-formulary. Requests from providers for new drugs are handled on a one-time drug request for individual patients. If use of the new drug evolves into frequent individual requests, formulary status of the drug is determined by the Pharmacy and Therapeutics Committee.

DEPARTMENT OF VETERANS AFFAIRS

RESPONSES TO POST-HEARING QUESTIONS
CONCERNING THE JUNE 11, 1996
HEARING ON
OTC PRESCRIPTIONS AT VA FACILITIES
FOR MR. JOHN OGDEN
DIRECTOR, VA PHARMACY SERVICE

SUBMITTED BY
LUIS V. GUTIERREZ
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HOUSE VETERANS' AFFAIRS COMMITTEE

Question: Mr. Ogden, you state in your testimony that no later than May 1, 1997, the VA will have in place a national formulary. How will this national formulary work with the VISN regional formularies? Will regional flexibility be built into the system or will policy be set at the national level?

In particular, will local VA hospitals that serve a large number of low-income, homeless and persons with disabilities be granted greater range in the provision of OTC drugs due to their individual demographics?

Answer: The Veterans Health Administration's national formulary will replace VISN-level formularies. However, local flexibility will be an integral part of the national formulary process. This flexibility is necessary to address patient indiosyncracies. In fact, as part of the policy concerning the development of the national formulary, local flexibility will be defined as a critical element in the effective management of the formulary.

The range of over-the-counter drug products, medical/surgical supplies and nutritional products listed on the national formulary will be reflective of those items necessary to care for veteran patients across the entire VA health care system. As stated above, local flexibility to utilize a drug or other pharmacy supply not on the national formulary is a critical foundation in the creation of the national formulary. This flexibility is important to ensure that local VAs have the ability to meet their patients' needs.

ATTACHMENT TO QUESTION #3, ASHEVILLE, NC, VA MEDICAL CENTER

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

VHA DIRECTIVE 10-95-111

November 7, 1995

IMPLEMENTATION OF VETERANS INTEGRATED SERVICE NETWORK FORMULARIES

1. PURPOSE: The purpose of this Veterans Health Administration (VHA) Directive is to implement Veterans Integrated Service Network (VISN) drug formularies.

2. BACKGROUND

a. VHA's historic and current policy on drug formularies directs a local formulary and formulary process. While this local process has historically benefited facilities with increased flexibility, it has also led to considerable formulary variation between facilities. The variation results in a lack of standardization, increased inventory costs, and less competitive prices for pharmaceuticals. As patients begin to access care across VHA's new integrated networks, the variation in pharmaceuticals available at facilities has the potential to disrupt continuity of care, negatively impact customer service and frustrate patients.

b. Consistent with practices in other large managed care organizations, VHA's new policy supports VISN-level drug formularies and formulary processes. The advantages of a VISN formulary include increased standardization, decreased inventory, increased efficiency, and lower pharmaceutical prices through enhanced competition. However, the primary advantage of a VISN formulary is the continuity of care that results from a network-wide approach and the improved service provided to veterans.

c. The National Acquisition Center will establish flexible contracting options for pharmaceuticals (e.g. committed volume, tiered discounts, incentive contracts, etc.) which will allow VHA to realize the benefits of VISN formularies through the achievement of volume discounts. VISN requests for contracting options should be coordinated through the Chief, Drugs and Pharmaceuticals Product Management (DPPM) to maximize VHA's opportunities for discounts and to assure availability of product throughout prime vendor.

3. POLICY: The policy of the Veterans Health Administration is to provide consistent, high-quality health care to its patients in a cost-effective manner. This policy includes the development and maintenance of a VISN-level formulary which provides for the pharmaceutical needs of the VISN's population.

4. ACTION: Each VISN will implement a VISN-level formulary process by November 15, 1995, and a VISN formulary by April 30, 1996.

a. VISN Directors will immediately identify a formulary team leader as liaison between the VISN, the Chief Network Officer (CNO), and Patient Care Services. The liaison assignment may be managed as a collateral assignment of a VISN or facility employee. The liaison must be a member of one of the VISN's facility-level Pharmacy and Therapeutics Committee. The name, location, phone number, and fax number of the liaison should be faxed to the Chief, Drugs and Pharmaceuticals Product Management (DPPM) at 708-216-2088 by November 15, 1995.

b. The type of formulary process used to develop the VISN formulary is at the discretion of the VISN Director. An example of the process used by the Western Pennsylvania Network is provided for informational purposes (see att. A). VISN level formularies do not necessarily require a change in the facility level formulary process, but changes should be considered as a mechanism to assure integration of local and VISN decisions.

c. To achieve VHA's contracting objectives, the VISN formulary must be a closed formulary as opposed to an open formulary or "core" formulary. The VISN formulary should contain a reasonable number of products within a therapeutic class to address the bulk of patient requirements. The VISN formulary may restrict the use of certain products to certain facilities, sites (inpatient/outpatient), or providers. The non-formulary approval process based on clinical need should be a part of the VISN formulary development process.

THIS VHA DIRECTIVE WILL EXPIRE NOVEMBER 7, 2000